Temora

Health Service Plan

October 2022

Version 2.5

Final

DOCUMENT ADMINISTRATION

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Table of contents

Table of Figures

Tables

1. EXECUTIVE SUMMARY

Temora Health Service operates within Murrumbidgee Local Health District (MLHD) in a hub and spoke model, linking with Wagga Wagga Base Hospital (WWBH). Temora is in the Small Community Hospital with Surgery peer group. Most services operate at a Role Delineation Level (RDL) 1-3 (Appendix 1). Temora Health Service is part of a Cluster management structure with Cootamundra Health Service, Gundagai Multipurpose Service (MPS) and Coolamon MPS.

MLHD was formed on 1 January 2011. It is one of seven Rural LHDs in NSW. MLHD covers 21 Local Government Areas (LGA's) spread across 125,561 square kilometres. It includes 33 geographically spread health facilities (including Mercy Health Albury and Young) and several community health centres.

The Temora Health Service currently accommodates 28 inpatient beds, a Role Delineation Level (RDL) 2 emergency department, maternity and surgical services, community health services, clinical/ non-clinical support services, and staff accommodation. It is situated in the township of Temora which is the largest town in the Temora Local Government Area (LGA), approximately 80 kilometres (km) north of Wagga Wagga.

This Service Plan has been developed to identify appropriate services for the Temora community and extended catchment for the next 10 years and beyond. Service planning is underpinned by State and District strategic directions, strategies, and policy and MLHD planning principles. Planning is informed by the catchment population profile, political, economic, technological, legal, and environmental factors.

This Service Plan responds to internal District wide planning for rehabilitation services, opportunities to review flows for Temora residents to Wagga Wagga and other MLHD facilities, potential redirection of inpatient services to non-admitted services and the opportunities to provide more services closer to home through digital and technological enhancements and District support networks.

Temora Health Service planning aims to identify appropriate services for the catchment within the context of MLHD planning principles. Service planning is underpinned by State and District strategic directions, strategies, and policy.

The community area for the Temora Health Service for planning purposes is the whole of Temora Local Government Area (LGA), the population and health statistics included will therefore be at the Temora LGA level. The estimated resident population as of June 30, 2020, was 6,274. The proportion of the population aged 65 years or older was 25.4% % compared to 16.7% in NSW; 2.8% of Temora residents identify as Aboriginal and/or Torres Strait Islander.

Temora on average has a higher proportion of 65+ years than most other LGAs in MLHD.

Changing population demographics will have a significant impact on the future demand for primary health/ health education services, chronic disease management,

acute/ sub-acute care, and aged care services. More broadly, an increased demand for social services is anticipated, particularly youth and older person's mental health.

The health service works in close partnership with the Murrumbidgee Primary Health Network (MPHN), Non-Government Organisations (NGO's) and other human service providers, to provide linked up services. The Integrated Care Strategy is an important component of this work. Temora Health Service is also supported by a committed eight members LHAC and an active Hospital Auxiliary (approximately eight to nine active members).

Planning for Temora Health Service is informed by a review of where Temora residents access health services, and where people come from to access services at Temora. Most non-locals accessing Temora Health Services are from Young and Cootamundra.

Residents of the Shire access nearly half their services at Temora Health Service followed by Wagga Wagga, private hospitals/ day procedure facilities, Young, Cootamundra and the small remainder at numerous other health services. Most of the demand for services provided elsewhere was for overnight acute services.

As indicated above, besides Wagga Wagga and private facilities, most residents accessing services outside of Temora were provided at Cootamundra and Young Health Services. This would make sense because these facilities are only 58 and 80 kilometres from Temora respectively and have similar and some higher-level services. Flows for higher level services from each of these facilities tend to go to WWBH or private services.

The main use of services provided at WWBH and NSW private services by Temora residents are for:

- Orthopaedic services (Wagga Wagga)
- General Surgery
- General Medicine
- Gastroenterology
- Cardiothoracic Surgery (private)
- Diagnostic gastrointestinal endoscopy (private); and
- Ophthalmology (private).

Renal dialysis is provided at Wagga Wagga and chemotherapy at private day procedure centres.

There are opportunities to investigate better patient referral and transfer protocols between the three hospitals at Temora, Cootamundra and Young, rather than relying on transfers to WWBH. This will provide opportunities for people to be treated at an appropriate level facility which may be closer to home

Activity at Temora Health Service indicates that:

- Average inpatient occupancy has been low over the past five years (31%-38%)
- Average occupancy for the six maternity beds has been one bed per day for the past five years

- Surgical activity was in decline till 2017/18 but increased over the next two years because of one doctor performing a range of minor procedures
- During the five years, day surgery activity accounted for about 79% of all surgical activity. On average, surgical, and procedural activity over the five years accounted for 0.12 to 0.21 beds
- Transitional Aged Care community places had low site occupancy rates at Temora, however a District approach will ensure access by Temora residents while ensuring better utilisation of the places across the District
- Emergency department presentations decreased over the last two years, potentially because of CoVID-19
- The services with the biggest annual increase for Non-Admitted Patient activity over the last five years was Physiotherapy Clinic, Nursing Post-Acute Care, Pathology Services, Mental Health and Drug and Alcohol Services
- In 2018/19, patients under the clinical services of General Medicine, Obstetrics, Respiratory Medicine, Gastroenterology, Cardiology, General Surgery, Orthopaedics made up the largest proportion of patients being admitted

The top five Enhanced Service-Related Groups (ESRG's) making up the highest number of bed days for all age groups were:

- Maintenance care
- Respiratory infections/inflammations
- Chronic obstructive airways disease
- Surgical follow up
- Heart failure & shock
- Injuries and
- Other general medicine

"Stand out" issues for Temora LGA are:

- Relatively low socioeconomic status and welfare dependency
- Relatively high levels of disability
- Ageing population both in proportion in older age groups and actual increases in numbers of older people
- Smoking
- Obesity/overweight and
- Most major causes of hospitalisation are elevated indicating a high level of ill-health in the population

Population demographics indicate a need for improved health literacy and access to chronic disease management programs and services. Demand in this area is growing as is demand for aged care services and mental health/ drug and alcohol services across care settings. Stakeholder consultations confirmed this need.

Access to GP services is generally same day. There are GP services available some Saturdays.

A new rehabilitation service including both outpatient and inpatient services commenced in November 2016, which is providing care closer to home for longer stays and reducing the need to access clinics in Wagga Wagga.

Inpatient demand is projected to remain relatively stable at the Temora Health Service. The largest growth in demand will be for people aged 70 and over. There are opportunities to use an out of hospital care/community-based models such as adult Hospital in the Home (HITH) or improved outpatient services to offset inpatient demand.

Temora Health Service will provide a RDL 3 ED service as well as the current GP COAG 19(2) service and Mental Health Emergency Consultation Service (MHECS). Virtual Care will be an integral component of the model for bedside critical care advice and support through the Patient Flow Unit. There will be an enhancement of Virtual Care modalities to provide additional clinical support and advice.

The current facility has some challenging limitations for implementing contemporary models of care. The dislocation of the emergency department on the ground floor in what is otherwise an eight-hour zone creates challenges for after-hours staffing as staffs covers both the inpatient unit and ED.

An Audit conducted in 2019 identified that the operating theatre at Temora was compliant with current Australian Standards after the refurbishment in 2018. MLHD aspires to work towards a RDL 3 surgical service at Temora to meet MLHD's aim of maintaining an unyielding focus on quality and safety[1] and care as close to home as possible.

It is proposed that Temora Health Service undergoes master planning to improve functional relationships for existing and planned services. Future inpatient services will continue to provide acute and sub/ non-acute services in line with role delineation levels. Services will be provided across care settings through increased service integration and partnerships with other providers.

Service recommendations to meet projected demand and models of care include:

- RDL 3 ED
- 24 Inpatient beds including a 4-bed rehabilitation pod with rehabilitation clinical support service areas (Activity of Daily Living areas) and maternity beds
- A level 3 Maternity service supported by a level 2 Neonatal service
- RDL 3 surgical services with a fully functional Operating Theatre and Procedure Room with general anaesthetic capabilities
- Hospital avoidance/ out of hospital services (e.g., outpatient clinics/ outreach/adult HITH)
- Enhanced and collocated community health services.
- RLD 3 Radiology service
- RDL 3 Pharmacy
- RDL 3 Pathology service and
- Staff accommodation

A number of options were investigated

The recommended configuration is based on projected service need with reversal of some flows for rehabilitation services able to be provided at Temora. It is

[1] MLHD Strategic Plan 2016-2021

recommended that consideration is given to improving models of care and repurposing existing spaces to improve functional relationships. This may require capital investment.

Table 1: Temora bed/space table – *excluding standard components associated with individual Health Planning Units*

Areas	Existing	Proposed 2036
ED		
ED Resuscitation Bays	1	1
ED bays	2	2 – 1 X enclosed (child safe)
ED isolation room	0	1
Quiet/ low stimulus room – used also for MH assessments (not a safe assessment room)	0	1 X low stimulus
ED treatment room	0	1
Total ED spaces	**3**	**6**
Inpatient beds		
Inpatient beds	28[2]	20[3]
Rehabilitation	0	4[4]
ADL facilities	0	ADL Kitchen, laundry, dining/ lounge
Total inpatient beds	**28**	**24**
Maternity Spaces (excluding inpatient beds)		
Birthing room	1	1 – with immersion bath for pain relief
Large Maternity assessment room	1	1 - able to flex up for birthing room if required
Neonatal Nursery – Nursery/neonatal resus/milk storage room/ immunisation/ baby check (2 separate fridges required – 1 milk, 1 vaccine)	1	Yes - Inclusive of 2 nursery cots (manage twins reverse transfer), 1 resuscitaire (with critical care camera), baby check area/immunisation, education space (bathing – model to be confirmed) and milk room
Support Spaces		
Family room with kitchenette (palliative care)	0	1[5]
Kitchenette for maternity and general inpatient access	0	1[6]
Interview/ meeting room	0	1[7]
Aboriginal liaison room (able to accommodate family groups)	0	1[8]
Education space for Nurse/Midwifery Educators	1	1[9]

[2] Currently 1 inpatient palliative care bedroom

[3] Includes general medical/surgical, palliative care, maintenance, maternity, close observation (2), paediatric safe beds, and requires cot and storage for same when not in use.

[4] A pod of 4 aligns with staffing and built environment for rehab services, noting flexible use of beds and appropriate space also for maintenance patients to reduce deconditioning.

[5] Model to increase access for multiple palliative care patient families. Access to outdoor courtyard required. All inpatient beds can be used for end-of-life care.

[6] May be on corridor in IPU – location to be confirmed during capital planning

[7] On edge of IPU or in main entrance area – location to be confirmed during capital planning

[8] In main entrance area – preferably with access to outdoor views/space – location to be confirmed during capital planning

[9] Location to be confirmed during capital planning (IPU or Wellness Centre)

Areas	Existing	Proposed 2036
Operating Suite with standard components (AHFG's)		
Operating Theatre	1	1
Procedure Room **(With general anaesthetic capabilities)**	0	1
Recovery (Stage 1)	2	4
Recovery (Stage 2/3)	3 chairs	6/4
Clinical Support		
X-ray service	1 fixed, 1 mobile - ED	yes – 1 fixed, 2 mobile (ED and OT)
Ultrasound service	no	Yes - 1
CT service	no	yes - 1
OPG	no	Yes - 1
Pharmacy	yes	Yes
Pathology	PoCT	Yes – to meet level 3 role delineation[10]
Wellness Centre – not including workforce office and support areas		
Specimen Collection	nil	yes
Outpatient/ Community Health general consultation/treatment/interview rooms	2 MHDA, 0 outpt, CH - staff offices	12[11] – mix of consult/ treatment/ interview
Virtual care clinic space for community to access for remote specialist or GP appointments	Nil	2
Rehabilitation Program Gym (inpatients and outpatients) – full time dedicated Allied Health Assistant (constant use)	1 rehab assessment gym	1 rehab assessment gym located in Wellness Centre[12]
Dental	Yes 1 chair	Fixed dental clinic including 1 chair, sterile stock storage, education, and staff office accommodation, paediatric safe sub wait[13]
Group room large – used for cardiac and pulmonary rehabilitation, community exercise and falls prevention, and antenatal groups	Nil	1 large - in Wellness Centre (up to 40 participants) – requires storage for equipment, tables and chairs and audio-visual equipment
Large meeting rooms Used for operational meetings, education	1 (20 people)	2 in Wellness Centre (1 used daily to twice daily by MHDA team for patient review meetings)
Small meeting room Used for smaller operational meetings, Hospital Auxiliary etc	1 in mental health 7-10 people	1 in Wellness Centre – to meet the needs of increasing non admitted projects/programs and associated staff
Staff Accommodation		
Units for accommodating staff	Physically 10 only 5 currently fit for purpose	8-10 X units with ensuites and shared amenities adjacent to the hospital. Current 5 beds 100% occupancy.[14]

[10] NSWHP advise that the "increased requirements for Temora and surrounds support the need for a Hub-style laboratory to be located centrally within the Hilltops/Cootamundra shire District but does not necessitate further small on-site laboratories to be developed." Further discussions will occur with NSWHP during facility planning to ensure service continuity for pathology services at Temora.

[11] 2031 projections (not 2036)

[12] Requires 2 X plinths, fixed and loose exercise equipment, assessment space and a 10-metre gait assessment track, splinting/hand therapy and plaster facilities

[13] Space can be used flexibly by other services such as podiatry when not in use for dental

[14] Used for locum staff, student placement and short-term accommodation for new staff (12 weeks).

There has been significant stakeholder engagement and consultation throughout the development of this plan. There have been over 70 individual meetings (including via phone and zoom), email feedback, group sessions, town hall style meetings, survey feedback, community draft review, steering group involvement and endorsement, approval from MLHD Executive and Board. Feedback has been faithfully considered and incorporated, where appropriate, at each stage of the plan. The community has eagerly contributed at each phase of the plan and MLHD is grateful for their open engagement.

2. CONTEXT OF SERVICE PLAN

This Service Plan responds to District wide planning and reviews for rehabilitation services, surgical services, and non-admitted services. It incorporates recommendations based on quality and safety to reflect the NSW maternity and Neonatal Service Capability Framework review and NSW 2021 role delineation of services processes. Temora Health Service was identified in the MLHD Rehabilitation Plan for future development of a rehabilitation service to provide slow stream rehabilitation services. Existing service use and projected demand have been analysed to establish future service need. An assessment of existing infrastructure, models of care and workforce determine capacity to meet new service directions has been undertaken.

2.1 BACKGROUND

The Temora Health Service provides 28 inpatient beds (22 general and six maternity), a RDL 2 emergency department, community health services, clinical/ non-clinical support services, and staff accommodation.

Temora Health Service planning aims to identify appropriate services for the community within the context of MLHD planning principles as follows:

- Equity – individuals have equal opportunity to achieve their best level of health
- Access – Services are available, acceptable, and affordable
- Sustainability – balance ongoing needs with workforce availability and budget; and
- Ownership – communities are encouraged to own and manage their health and actively participate in their health care

Services are required across care settings with increased service integration and partnerships with other service providers.

Service planning is underpinned by State and District strategic directions, strategies, and policy. It is influenced by the catchment population profile and political, economic, technological, legal, and environmental factors. Planning is forward thinking providing scope for future changes to incorporate service innovations, enhanced technology and models of care. This section provides a background to the planning context for Temora Health Service.

2.1.1 POLICY FRAMEWORK

Planning for Temora Health Service aligns with *NSW: Making it Happen. NSW: Making it Happen* outlines 30 ‘State Priorities’ including 3 ‘Premier’s Priorities’ that together define the NSW Government’s vision for a stronger, healthier and safer NSW. The following priorities are to be reflected in strategic and operational plans for MLHD:

Premier's Priorities 2022

These priorities represent the government's commitment to making a significant difference to enhance the quality of life of the people of NSW.

The government's key priorities are:

- a strong economy
- highest quality education
- well-connected communities with quality local environments
- putting customer at the centre of everything we do
- breaking the cycle of disadvantage

Premier's Priorities

- Improving Service Levels at Hospitals – '81% of patients through emergency departments within four hours.'
- Improving outpatient and community care and
- Towards zero suicide deaths in NSW by 20% by 2023[15]

State Priority

NSW Health *Future Health*[16] outlines the roadmap for NSW Health over the coming decade**.** It provides the strategic framework and priorities for the whole system from 2022 – 2032, and will position the NSW health system to continue to meet the needs of patients, community and workforce.

It aims to deliver on NSW Health's vision for a sustainable health system that delivers outcomes that matter most to patients and the community, is personalised, invests in wellness and is digitally enabled.

The report identifies four main matters that will need to be addressed in the future. These include:

- The importance of involving patients in their own care, helping them to make their own decisions about the health outcomes that matter most to them
- The value of collaboration and partnerships, and how we can enhance this
- The potential of virtual care tools such as Telehealth in our future health systems and what it means for both patients and clinicians
- The need for more choice of care settings in the future – in the community, in the home and virtually[17].

The overarching vision for MLHD facilities and infrastructure is aligned to the NSW 20 Year Health Infrastructure Strategy as follows:

- MLHD facilities are sustainable, safe and pleasant for consumers and staff, with flexibility to meet projected service demand and support emerging models of care

[15] https://www.health.nsw.gov.au/priorities/Documents/strategic-priorities.pdf

[16] Future Health: Guiding the next decade of health care in NSW 2022-2032 health.nsw.gov.au/about/nswhealth/Documents/future-health-summary pdf

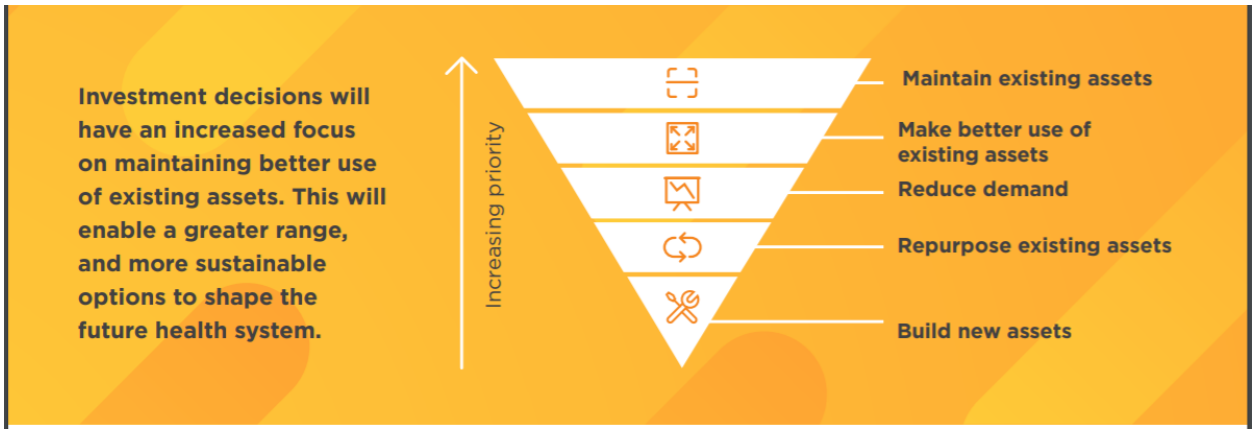
[17] Et al p. 4

Elements that support this vision include:

- demographic and social shifts
- expectations and benefits of personalised and consumer focused health services
- technological and digital innovation
- continuing advances in medical research

Master planning for any facility upgrades should therefore incorporate a 20-year horizon. The focus for infrastructure investment decisions at the State level is shown in the figure below.

Figure 1: NSW 20 Year Health Infrastructure Strategy Priority for infrastructure investment decisions



Source: NSW 20 Year Health Infrastructure Strategy

MLHD has a Service Agreement with the Ministry of Health to deliver the directions of a number of the key influencing plans such as Young People and Families 2014-2024; Living Well, A Strategic Plan for Mental Health in NSW 2014-2024; First 2000 Days Framework; NSW Aboriginal Mental Health and Wellbeing Strategy 2020-2025, End of Life and Palliative Care Framework 2019-2024; NSW Women's Health Framework; NSW Men's Health Framework; Strategic Framework for Suicide Prevention in NSW 2018-2023 and the Integrated Care Strategy. The Service Agreement outlines key accountabilities.

MLHD has a Service Agreement with the Ministry of Health to deliver the directions of the NSW State Health Plan, Rural Health Plan, and other key influencing plans such as Living Well, A Strategic Plan for Mental Health in NSW 2014-2024, and the Integrated Care Strategy. The Service Agreement outlines key accountabilities.

The Integrated Care Strategy vision is for seamless, effective, and efficient care provided through different health care providers and with an emphasis on community-based services. It aims to respond to all aspects of a person's health and is particularly targeted at supporting people with long term conditions and complex health needs.

The MLHD Strategic Plan Exceptional Rural Healthcare 2021-2026 outlines the vision, focus and investments required to deliver excellence in connected health care for our communities in partnership with others.

It identifies four strategic directions MLHD will be focusing on:

- Holistic health and wellbeing
- Lifting health outcomes
- Locally led reform
- Workforce at its best

The MLHD Clinical Services Framework (CSF) 2021-2026 aims to assess the challenges and detail the priorities and future directions for clinical service development and delivery for the next five years. It outlines future priorities, strategic directions and recommendations for clinical services across MLHD and individual hospitals[18].

It identifies a number of clinical services strategic priorities as follows:

- Optimise workforce resources
- Plan collaboratively
- Proactively align services and processes
- Optimise use of existing infrastructure
- Invest in change to enhance uptake of alternatives to inpatient care and
- Invest wisely using finite resources[19].

In addition to health policies and plans, health service planning for Temora must be cognisant of regional plans and Local Government plans. The Riverina-Murray Regional Plan outlines a vision for the region which 'is for a sustainable future, with strong, resilient local communities capable of responding to changing economic, social and environmental circumstances.' The Temora Shire 2030 Community Strategic Plan aims to reflect the qualities of its people, hold on to the strengths of the past and embrace change to enhance the environment, economy and lifestyle. Key action themes include:

- Retaining quality of life.
- Engaging and supporting the community.
- Building the Shire economy; and
- Preserving the environment.

Health service availability and health employment opportunities are critical enablers to maintaining vibrant communities in the rural context. Services must reflect the needs of the population, be viable and sustainable. The health service works in close partnership with human services providers to ensure a linked-up service for disadvantaged people and people requiring mental health prevention or specialist services. There are further opportunities to strengthen partnerships, including broader participation by services in interagency meetings and integrated care strategies.

[18] MLHD Clinical Services Framework 2021-2026 Draft v1.3 p. 6

[19] Et al p. 8

2.1.2 Factors Impacting Service Delivery at Temora Health Service

Temora has significantly poorer health compared to NSW for multiple indicators. Demand for chronic disease prevention and management is high, as is demand for mental health and drug and alcohol services.

People with multiple comorbidities (number of health problems) are also more likely to require higher levels of inpatient care and support services. This may account for the higher flows from Temora to WWBH compared to Young or Cootamundra.

Births have been declining over time, reflecting the shift towards an older population in Temora and neighbouring communities. Health services catering for illnesses related to ageing and programs targeted to older people are in high demand due to the increasing proportion of people over 70 years in the Temora LGA.

Surgical services are almost exclusively obstetric (caesarean sections). The service is sporadic by nature and further impacted by perioperative workforce availability. Inpatient nursing staff covers theatre sessions due to the low number of procedures undertaken. There is no medical theatre cover on weekends. Women who are likely to birth and are at a high risk of needing intervention are contacted and alternative service options at WWBH are put in place. The availability of suitably trained perioperative nursing staff is critical to maintaining a surgical service. The service is currently at a point of failure due to a lack of available staff. There is an issue with gaining and maintaining skills due to the very low volume of surgery.

Over time there have been changes in service provision at the hospital reflecting the changing demographics and changes in models of care. There is now an emphasis on keeping people healthy and out of hospital through improved management in the community.

Vacant clinical areas such as former inpatient areas have been repurposed as service shifts occurred. A whole of facility review to improve functional relationships for existing and planned services has not occurred for some time.

An Ambulatory rehabilitation service has recently been established next to maternity services in the former paediatric space. Community health services are now also in an old ward area on the ground floor. Staff offices are collocated within community health clinical space. Functional relationships are poor.

Contemporary models of care and appropriate infrastructure impact on staff recruitment and retention. Rural workforce enhancement is a constant challenge for rural LHD's. A high-level workforce plan for Temora Health Service has been undertaken in conjunction with development of this Service Plan. Multiple strategies have also been implemented to improve recruitment processes and attract staff, with a good reduction in vacancies across MLHD as a whole.

Challenges remain with the sub specialisation of many health professions in the metropolitan training environment, leading to a dearth of generalist providers, preferred in the rural setting. Inpatient demand for the older age groups in rural setting is increasing, reflecting community demographics.

MLHD is in the midst of e-health upgrades, which is changing the landscape of rural health service delivery. Improved bandwidth is a core component as an enabler for Electronic Medical Record (EMR) implementation. EMR was rolled out in Temora Health Service in 2016 as was the Community Health Outpatient Clinics (CHOC) software which captures non-inpatient data.

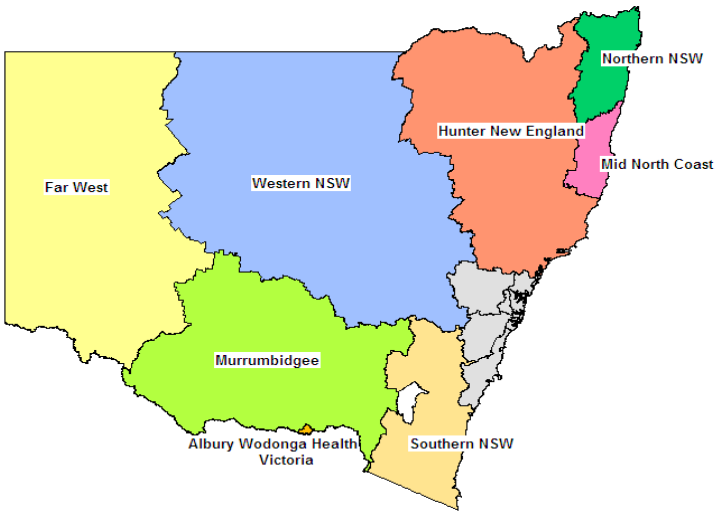
Patient Flow Unit was established in MLHD to support smaller rural sites with patient management and appropriate patient transfers in conjunction with the Critical Care Advisory Service component linked through Emergency Department (ED) cameras. This service has provided additional support for GP's and Nurses in the emergency department setting, which is critical for staff retention.

The Hospital in the Home (HITH) programs currently only operates for adults at WWBH and Griffith Health Service. There are opportunities to explore the viability of providing HITH or a similar service model (for adults) in smaller health facilities such as Temora. Repurposing existing space may provide opportunities to link a HITH type model with ambulatory care/ outpatient and other integrated care services.

2.1.3 Service Location and Transport

The MLHD was formed on 1 January 2011. It is one of seven Rural LHDs in NSW (Figure 1). The MLHD covers 21 Local Government Areas spread across 125,561 square kilometres (Figure 1a). It includes 33 geographically spread health facilities and several community health centres. Most of the LHD is considered inner regional or outer regional in terms of remoteness. The largest towns are Wagga Wagga, Griffith, and Deniliquin. Albury is generally part of Albury Wodonga Health; however, some MLHD health services continue to be provided in this community.

Figure 2: NSW Rural Local Health Districts (LHDs)



The Temora Health Service is situated in the township of Temora which is the largest town in the Temora local government area. The Temora LGA is in the central eastern region of the MLHD and is in the South West Slopes/Riverina area of NSW. It is approximately 80 km north of Wagga Wagga, Canberra is two hours (200kms) to the east and Griffith a one and half hour drive to the west. Temora is approximately 425 km southwest of Sydney and 530 kilometres north-east of Melbourne (Figure 1B).

Table 2: Distance from Temora Township to nearest cities and towns (by car)

Town	Distance from Temora (Kilometres)	Approx. travelling time (hours)
Cootamundra	55	0:45
West Wyalong	70	0:50
Young	80	1:00
Wagga Wagga	86	1:00
Griffith	152	1:45
Albury	211	2:25
Canberra	207	2:30
Sydney	423	4:30
Melbourne	534	5:40

Source: Google maps

Figure 1B: MLHD showing Temora catchment in relation to capital cities.

Source: Public Health, MLHD, created using Esri ArcGIS software.

Temora is located on the junction of the Burley Griffin Way (B94), which links Canberra to Griffith and the Goldfields Way (B85) north to West Wyalong and south via Junee to Wagga Wagga.

Rural public transport options are limited. A Sydney to Mildura bus service is available daily, which comes through Temora mid-afternoon heading west via Griffith, and mid-morning heading back to Sydney. Coach services to Griffith take approximately 2 hours. Temora to Sydney requires a change in Cootamundra with a two hour stop over, taking approximately 8.5 hours.

Coach services operate between Temora and Cootamundra daily, taking approximately 50 minutes. These links to rail services to Wagga Wagga; taking approximately one hour.

There are multiple providers of subsidised Community Transport for eligible residents including local services and transport to Wagga Wagga (see http://www.seniorservicesguide.com.au/list/Transport/australia/nsw/temora+shire+council+lg/temora). Access to the NSW Government Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS) is available for people having to travel significant distances for specialist treatment that is not available locally.

2.2 CATCHMENT COMMUNITY AND SOCIO-DEMOGRAPHIC PROFILE

Data assumptions in this plan were based on the 2016 ABS Census. The 2021 Census was released after the draft document had been circulated. The data update has been considered and population forecasts will not impact planning assumptions significantly, they are not the basis of decision making.

The median age of the population in 2020 was 46.5 years for Temora, slightly older than the median age for NSW at 42.4 years. The proportion of the population aged 65 years or older was 25.4 % compared to 16.7 % in NSW (Table 3). Temora on average has a higher proportion of 65+ years than most other LGAs in MLHD.

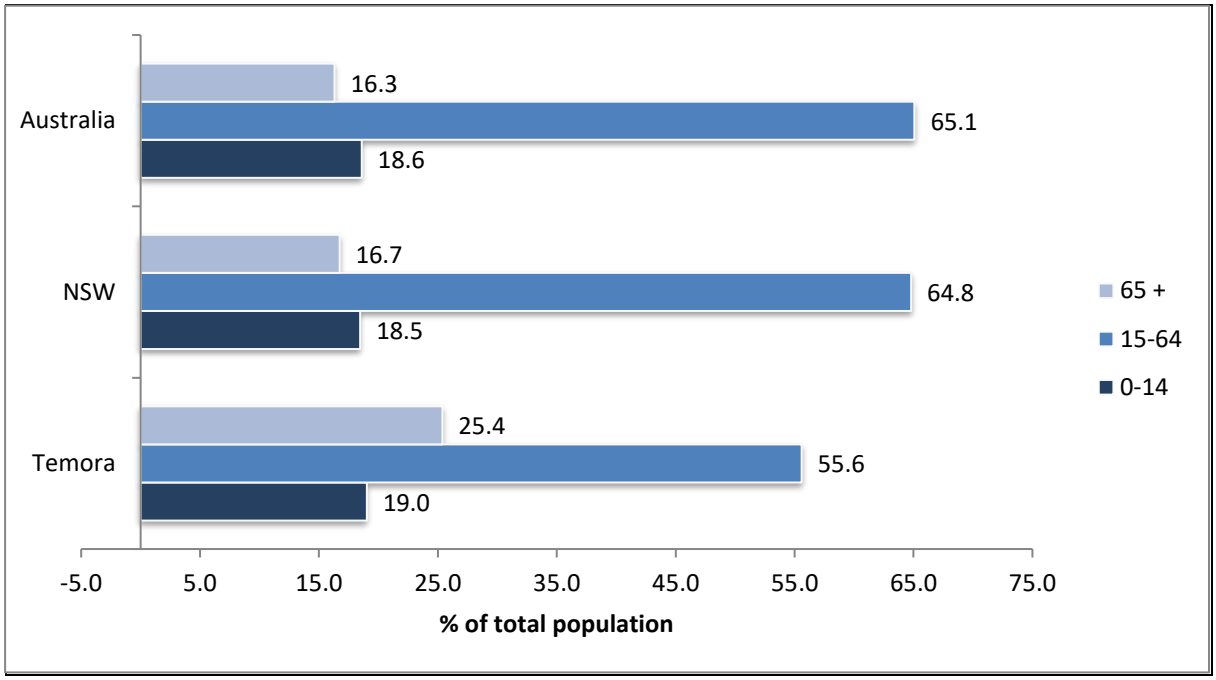
Table 3: Summary demographic characteristics Temora LGA and NSW

Area	Males	Females	Total	Aboriginal population 2016 ERP		Median age	0–14 years		65 years and over		70 years and over	
	N	N	N	N	%		N	%	N	%	N	%
Temora	3115	3159	6274	175	2.8	46.5	1194	19.0	1592	25.4	1164	18.6
NSW					3.0	42.4		18.5		16.7		11.8
Australia					3.1	37.8		18.6		16.3		11.4

Source: ABS Estimated Resident Population June 30, 2020, for NSW and Australia, Aboriginal data from 2016 ERP (ABS).

Temora LGA has a similar proportion of children to NSW and Australia, but a lower proportion of those aged 15-64 years with significantly more people aged 65 years or over (Figure 3).

Figure 3: Age distribution comparison Temora LGA, NSW, Australia, 2020



Source: ABS Estimated Resident Population June 30, 2020, August 2021.

Estimated Resident Population

Population growth from 2015 to 2020 for Temora LGA had indicated an annual increase of approximately 30 people per year from 2016 to 2019 with a drop of 33 in 2020 ERP. The net change from 2016 to 2020 was an increase of 64 people (1.8% increase). The biggest change in the Temora population has been the growth in the population aged 65+ years where the population has increased by approximately 200 people.

Population Projections

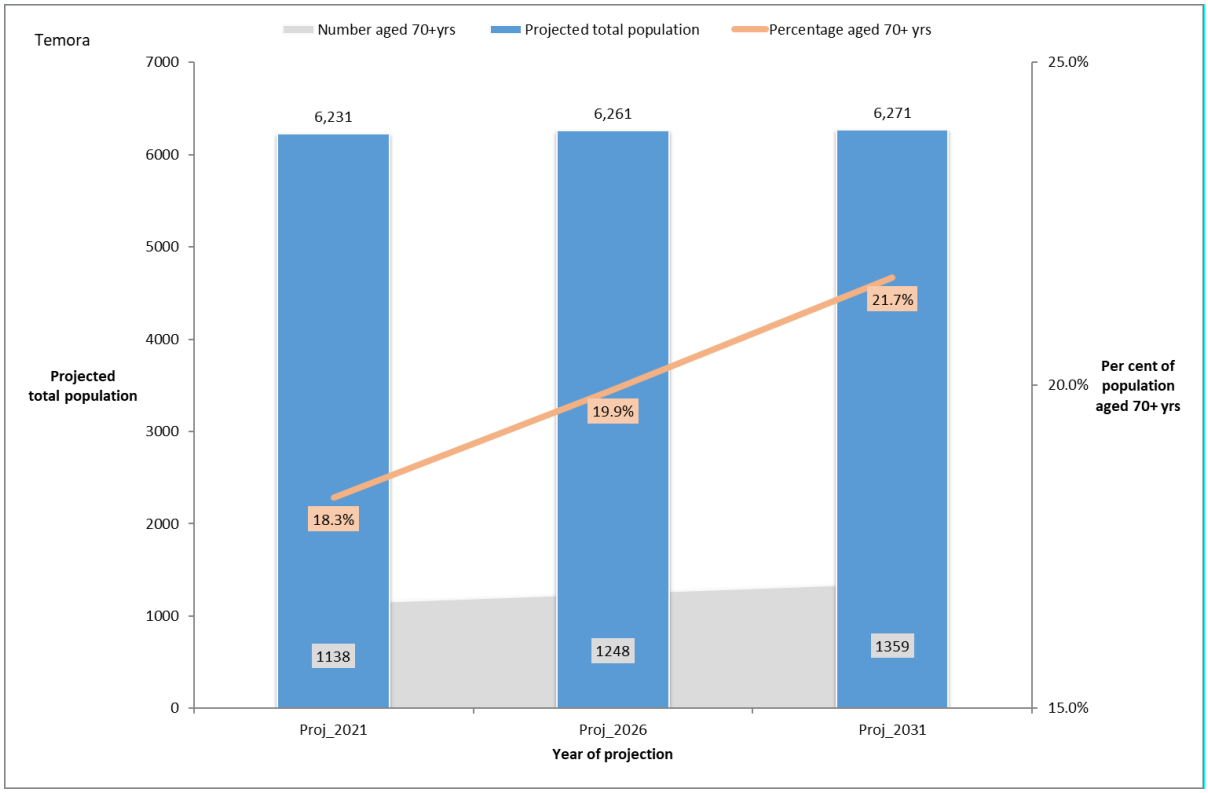
Population projections for Temora LGA indicate a slight increase over the next decade of approximately 30 people in the first five years and a further 10 people from 2026 to 2031 (Table 3 Data Book), the population is then predicted to decline. The proportion of older people, however, is predicted to increase over time with those aged 70 years or over making up 18.3% of the population in 2021 rising to 19.9% in 2026 and 21.7% in 2031. This is a predicted increase of approximately 100 people aged 70+ years per year. (Table 4)

Table 4 Temora LGA population projections, 2016 to 2041

	P2016	P2021	P2026	P2031	P2036	P2041
00-04	399	313	320	319	317	313
05-09	435	431	360	368	366	360
10-14	396	431	428	366	373	368
15-19	389	371	399	393	340	343
20-24	257	274	257	268	254	220
25-29	312	292	292	275	284	271
30-34	288	365	347	340	322	330
35-39	282	319	384	369	355	337
40-44	327	289	328	385	371	353
45-49	400	329	295	334	384	371
50-54	444	407	343	312	352	399
55-59	434	435	402	348	319	359
60-64	416	430	433	405	358	332
65-69	428	407	425	430	406	366
70-74	348	403	390	410	418	398
75-79	268	317	373	368	391	402
80-84	188	213	255	306	307	330
85+	199	205	230	275	340	381
All ages	6210	6231	6261	6271	6257	6233
Change from previous year		+21	+30	+10	-14	-24
65+	1431	1545	1673	1789	1862	1877
% 65+	23.0%	24.8%	26.7%	28.5%	29.8%	30.1%
Change in 65+yr from previous		+114	+128	+116	+73	+15
70+	1003	1138	1248	1359	1456	1511
%70+	16.2%	18.3%	19.9%	21.7%	23.3%	24.2%
Change in 70+yr from previous		+135	+110	+111	+97	+55
80+	387	418	485	581	647	711
%80+	6.2%	6.7%	7.7%	9.3%	10.3%	11.4%
Change in 80+yr from previous		+31	+67	+96	+66	+64

Source: 2019 Department of Planning and Environment Population Projections, 2016 ERP base.

Figure 4: Population projections for the former Temora LGA, all ages and 70+ years 2016 to 2026



Source: NSW Department of Planning and Environment (2019)

These changing population demographics will have a significant impact on the future demand for services related to ageing; primary health/ health education services, chronic disease management, and acute/ sub-acute care. Demand for paediatric services is likely to remain constant or decrease slightly.

Indigenous Population

The Estimated Resident Population of Aboriginal people in Temora area for 2016 was approximately 175 which was 2.8% of the total population compared to 3.0% in NSW and 3.1% in Australia including 34 people aged over 50 years (2016 ABS ERP).

In the 2016 Census the median age of Aboriginal people in Temora was 24 years, far younger than the Temora median age of 46.5 years (NSW Aboriginal median age of 22 years). The median household income for Aboriginal people was $782/week compared to the total Temora LGA household median of $1,033/week. In NSW, the median household income for Aboriginal people was $1,214/week and for all households $1,486/week.

Cultural and Linguistic Diversity (CALD)

Eighty-eight % of Temora residents were born in Australia, and 3.1 % spoke a language other than English at home the majority of these were Vietnamese, Tagalog, and Italian (2016 ABS Census).

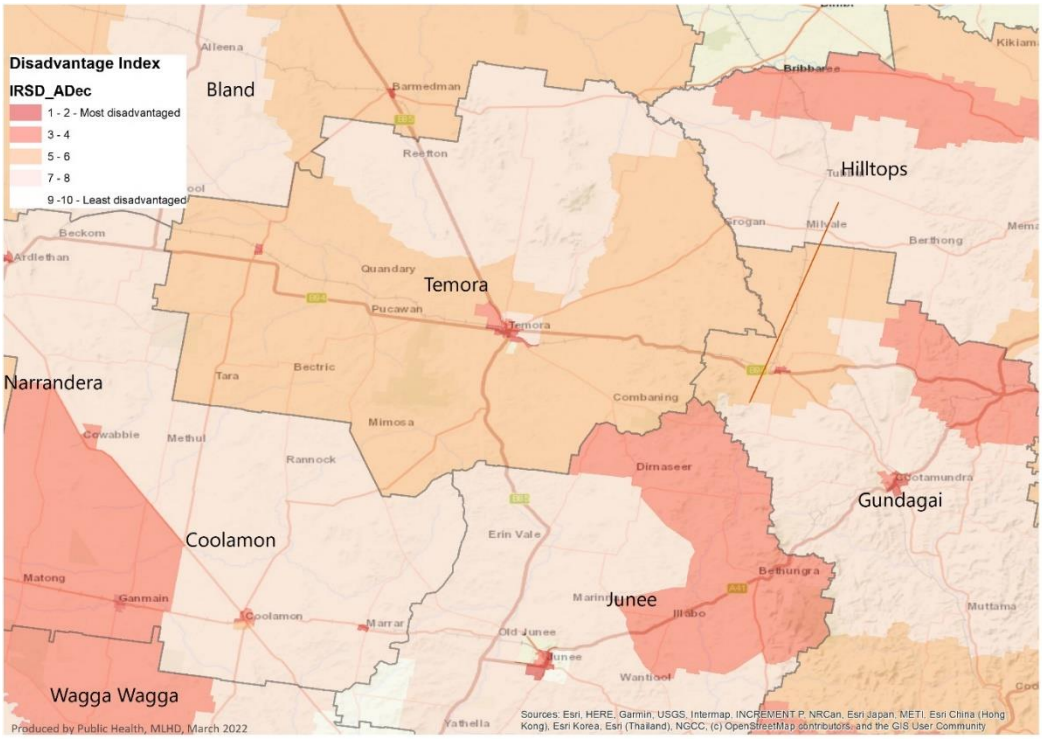
Socio-Economic Status

The health and wellbeing of individuals and communities is strongly linked to socio-economic factors where it is well documented that those who are socio-economically disadvantaged have poorer health. The Australian Bureau of Statistics Index of Relative Socio-economic Disadvantage is a score calculated on the percentage of the population in a particular area (such as LGA) with certain characteristics related to disadvantage (e.g., low income, high unemployment, low skilled jobs, and fewer qualifications). The scores for all areas across Australia are then put in order, given a ranking and divided into 10 groups (deciles), with Decile 1 being the 10% most disadvantaged areas, and Decile 10 the 10% least disadvantaged areas.

The Temora LGA is among the 50 % most disadvantaged LGAs in Australia, with a disadvantage Decile of 5. Some areas in the township of Temora are among the 10% highest disadvantaged areas in Australia (Figure 5).

Remoteness Index of Australia (ARIA+ 2011) indicates that Temora is “outer regional”.

Figure 5: Socioeconomic Disadvantage by small area (SA1) Temora, 2016



Source: Public Health, MLHD, created using Esri ArcGIS software and ABS SEIFA data 2016, March 2022.

Local industries

The 2016 ABS Census reports the Temora area unemployment rate as 4.9 % (Australia 6.9%, NSW 6.3%) with an estimated labour force of 2,641. Of the employed people in Temora 6.5% worked in Grain-Sheep or Grain-Beef Cattle Farming. Other major industries of employment included Other Grain Growing 5.4%, Supermarket and Grocery Stores 4.2%, Local Government Administration 3.3% and Aged Care Residential Services 3.2%.

Pension Support

In June 2020, 10.3 % of the 0- to 64-year-old population of Temora LGA were Health Care Card holders (486 people); 29.8 % of people aged over 15 years were Pension Concession Card holders (1534) and 11.4 % of those aged 65 years or over were Seniors Health Card holders (183). The proportion of the population receiving combined pension categories was higher than NSW (Table 5) indicating that a large proportion of the Temora LGA is welfare dependent.

Table 5: Income Support Recipients June 2020, former Temora LGA

	Temora LGA		NSW
Pension type	**Number**	**% of eligible population**	**% of eligible population**
Age	983	61.1	59.0
Disability support	232	6.7	4.6
Female sole parent	57	4.5	3.3
Unemployment	300	8.7	9.0
Unemployment long term	174	5.0	3.8
JobSeeker Payment (22 to 64yrs)	250	8.1	9.1
Welfare dependent and other low-income families with children	146	9.0	8.8
Health Care Card holders (less than 65 years)	486	10.3	10.2
Pension Concession Card holders (15 years and over)	1534	29.8	21.1
Seniors Health Card holders (65 + persons)	183	11.4	10.4

Source: Social Health Atlas of Australia, Data by Local Government Area from Centrelink, PHIDU, June 2020, accessed March 2022.

Disability

On Census night August 2016, 388 people in Temora were classified as having profound or severe disabilities with 645 people providing unpaid assistance to persons with a disability. There were approximately 180 people under 65 years of age living in the community with a profound or severe disability and 207 aged 65 years or over (Table 6).

Table 6: Profound or Severe Disability 2016, Temora number and percentage

Disability status 2016	Temora		NSW
	Number	%	%
Unpaid assistance to persons with a disability (aged 15+ yrs)	645	13.1	11.6
People with a profound or severe disability (includes people in long-term accommodation), All ages	388	6.8	5.4
People with a profound or severe disability and living in the community, All ages	321	5.6	4.9
People with a profound or severe disability (includes people in long-term accommodation), 0 to 64 years	180	4.1	3.0
People with a profound or severe disability and living in the community, 0 to 64 years	180	4.1	3.0
People with a profound or severe disability (includes people in long-term accommodation), 65 years and over	207	15.4	19.1
People with a profound or severe disability and living in the community, 65 years and over	140	10.4	14.9

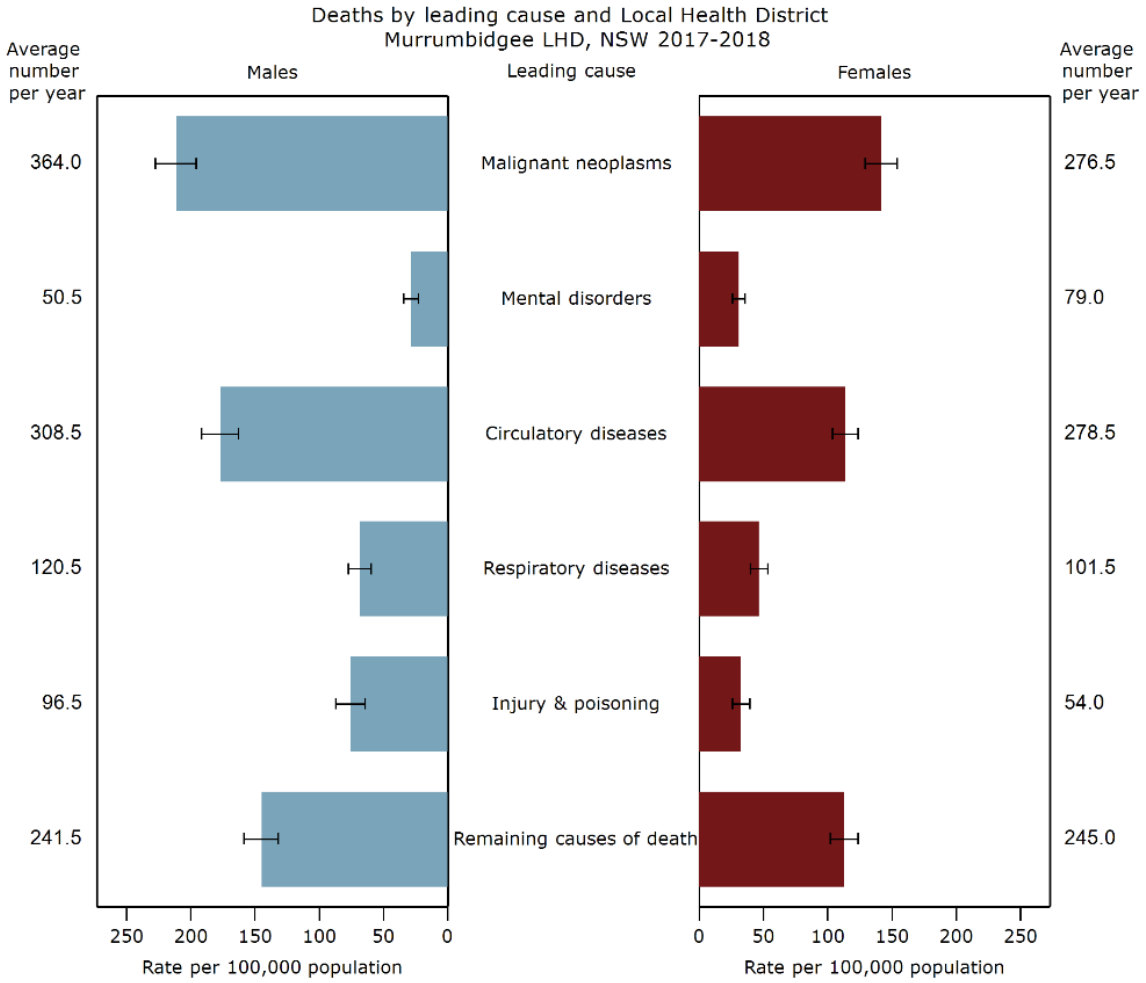
Source: Compiled by PHIDU based on the ABS Census 2016.

2.3 HEALTH OF THE POPULATION

Mortality

The age-adjusted “all cause” death rate for 2019 in MLHD was similar to the NSW rate (510.4 per 100,000 population compared to 513.8 per 100,000 in NSW). There were 2,372 deaths in MLHD 2019, and the death rate has overall been decreasing steadily for both males and females since the early 2000’s, the rate for males is significantly higher than the rate for females and both males and females in MLHD have decreased to near or below the NSW rates. The major causes of death for males and females are cancer followed by circulatory diseases (Figure 6).

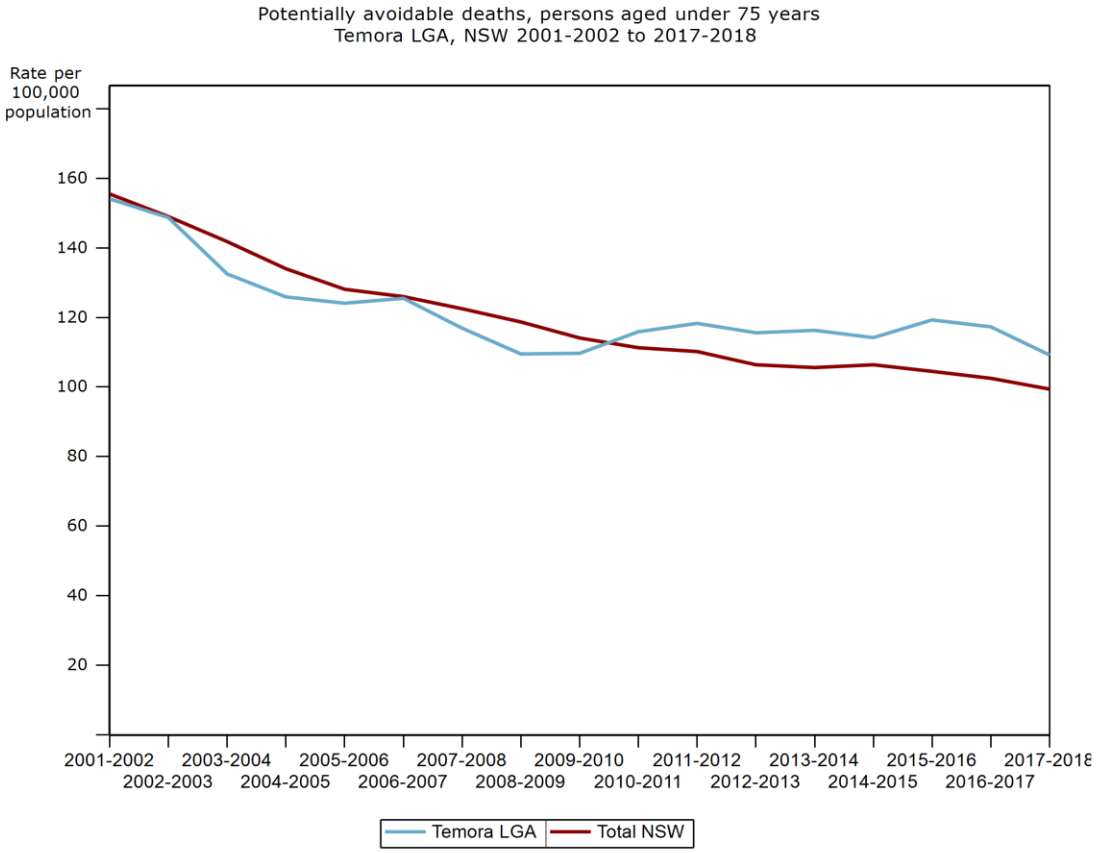
Figure 6: Causes of Death in MLHD 2017-2018



Source: Health Statistics NSW, March 2022

There was an average of 73.5 deaths per year (2017-18) for residents in Temora LGA at an age-standardised rate of 596.6 per 100,000 populations which was not significantly higher than the NSW rate of 520.9/100,000. The rate of death due to potentially avoidable causes for people aged under 75 years in Temora LGA has been declining, from 154 per 100,000 per year (around 9 deaths) in 2001-2002 to 109 per 100,000 in 2017-18 (around 6 deaths). Due to small numbers the rates can vary dramatically from year to year although there has been a general downward trend from 2001-2002 to 2009-10 then a plateau to 2015-2016 (Figure 7).

Figure 7: Potentially avoidable deaths Temora LGA and NSW, 2001-2002 to 2017-2018



Source: Health Statistics NSW, March 2022

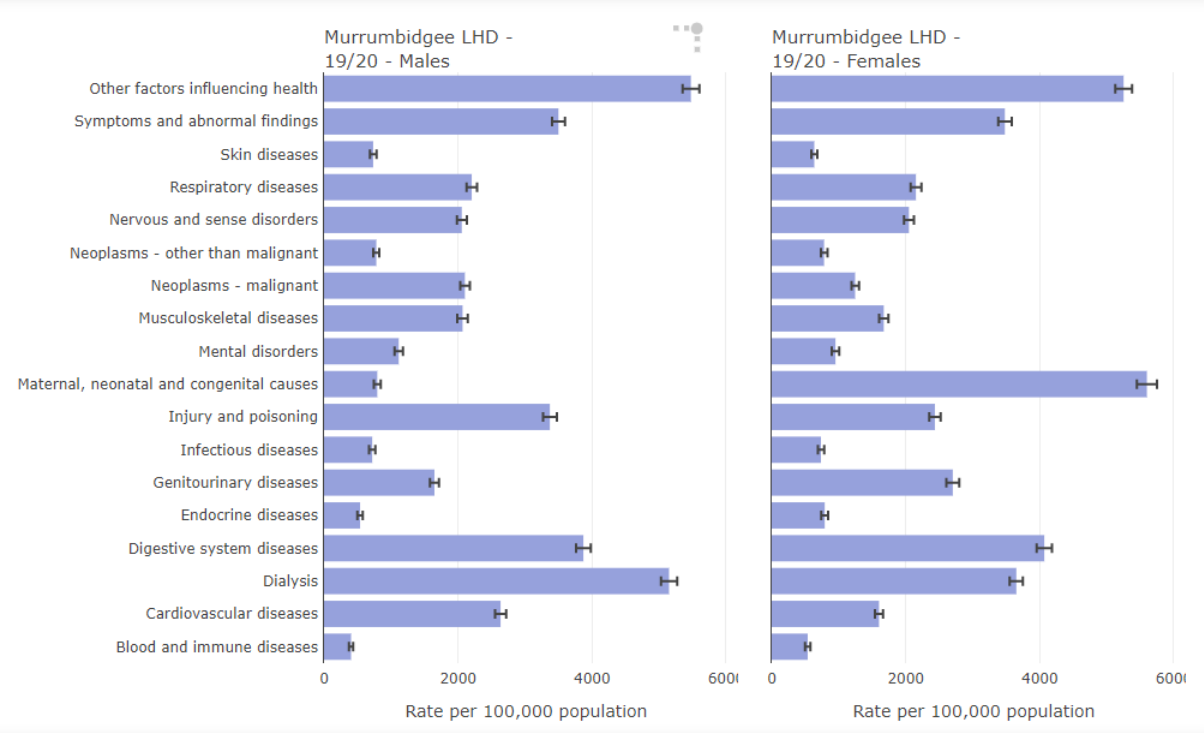
Morbidity (hospitalisation)

The most significant cause of hospitalisation in MLHD (2019-20) was “other factors influencing health care” (ICD10 Z-codes*) (15,724 episodes, 13.7%); followed by digestive system diseases (13,327, 10.5%), and then dialysis (12,630 episodes, 9.9%). The pattern for most causes was similar for males and females however the highest rate of hospitalisation for females was maternal and neonatal related diagnoses. Rates of separations for dialysis and injury were significantly higher for males compared to females (Figure 6)

Since the early 2000’s rates of separations for most major categories of cause have been increasing slightly, however the major contributor to increased separation rates overall for the MLHD had been the increasing rate of dialysis admissions which had doubled in 15 years (from around 3% of admissions in 2001-02 to around 10% in 2016-17) but has stabilised around the 10% mark. For MLHD residents the age-adjusted rates of hospitalisation by cause were significantly higher than the NSW rates for many causes (Figure 8).

Figure 8: Hospitalisation by cause and sex. MLHD 2018-19

**In 2016 in MLHD there were around 13,500 episodes with Z-codes although specific reasons for hospital contact are varied, some of the major reasons for these encounters were for chemotherapy (~4,000), newborns (~2,000), surgical care follow up (~1000) and endoscopic examinations (~500).*



Source: Health Statistics NSW, November 2020

Potentially preventable hospitalisations (PPH) are those that could potentially have been avoided through preventive care and early disease management, usually delivered in an ambulatory setting such as general practitioners or community health services (Figure 9).

Potentially Preventable Hospitalisation in 2019-20 in MLHD:
*The most frequent in terms of **admission numbers** (Figure 9):*

- COPD (1,115)
- Urinary tract infections (971)
- Cellulitis (860)
- Congestive cardiac failure (769)
- Dental conditions (752)
- Diabetes complications (563) *emerging issue ↑
- Iron deficiency anaemia (485)
- Ear nose and throat infections (465)

*Most common condition type by **total bed days** per year:*

- Chronic obstructive pulmonary disease (5,016 total bed days)
- Congestive cardiac failure (4,028 total bed days)
- Cellulitis (3,314 total bed days)
- Diabetes complications (2,954 total bed days)
- Urinary Tract Infections (2,779 total bed days)

*The causes with significant **increasing trend in admission rates** since 2001-02 were:*

- Pneumonia and influenza (vaccine preventable)
- Other vaccine preventable conditions
- Diabetes complications (increasing since 2012/13)
- Bronchiectasis
- Urinary tract infections
- Cellulitis
- Iron deficiency anaemia (increased dramatically to 2017/18 then dropped significantly to 2019/20)
- Ear, nose and throat infections (significant increases to 2018/19 dropped 2019/20)
- Dental conditions

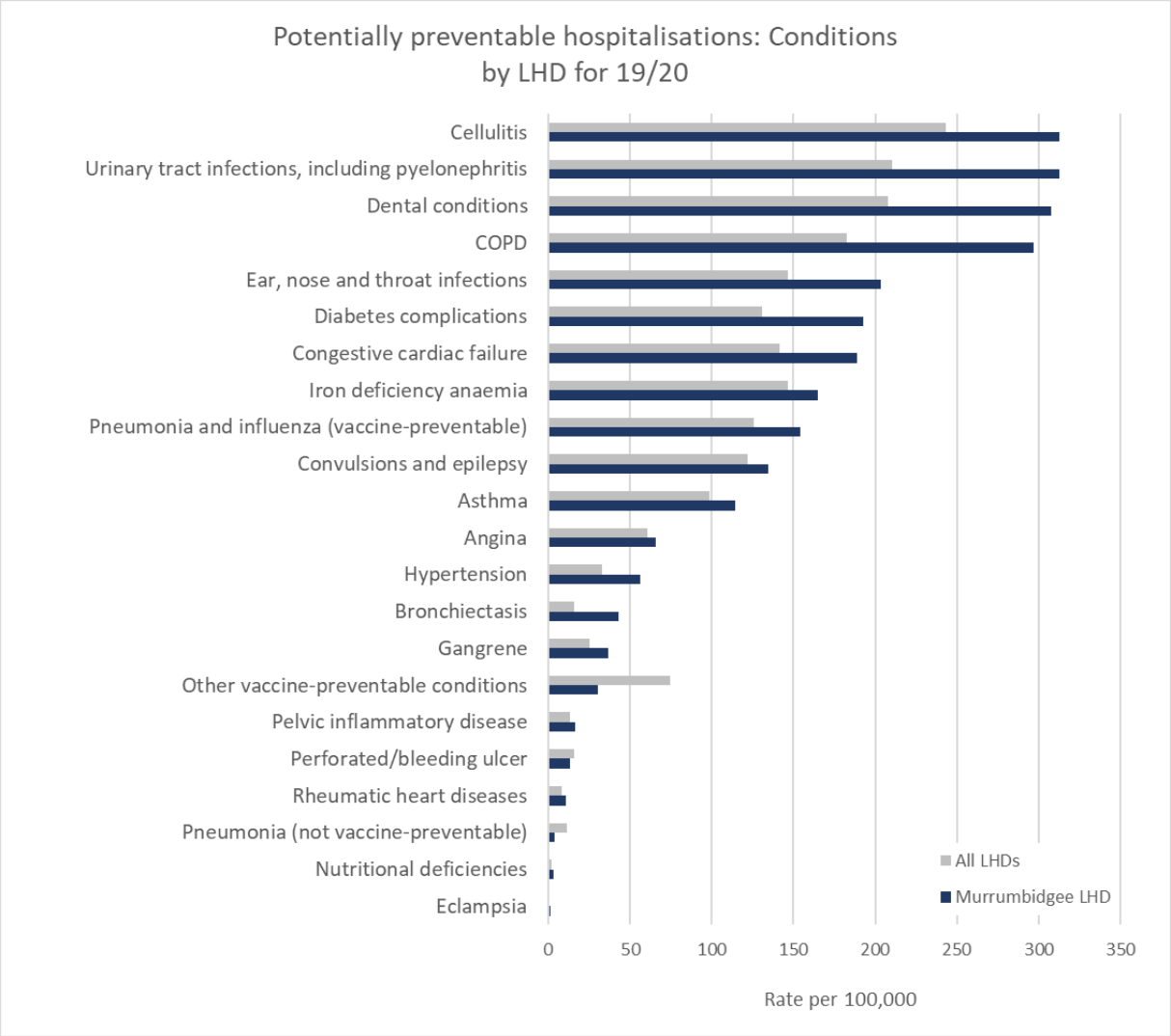
*Those with significant **decreases in admission rates** since 2001-02 were:*

- Congestive cardiac failure
- Angina
- COPD
- Perforated bleeding ulcer
- Pelvic Inflammatory Disease.

*The age-adjusted rates of PPH by condition in MLHD were **significantly higher** than the rates for NSW for the following:*

- COPD
- Urinary tract infections, including pyelonephritis
- Cellulitis
- Dental conditions
- Ear, nose and throat infections
- Congestive cardiac failure
- Iron deficiency anaemia
- Diabetes complications
- Asthma
- Bronchiectasis
- Gangrene
- Total preventable hospitalisations

***Figure 9*: Potentially Preventable Hospitalisation by cause MLHD 2019-20**

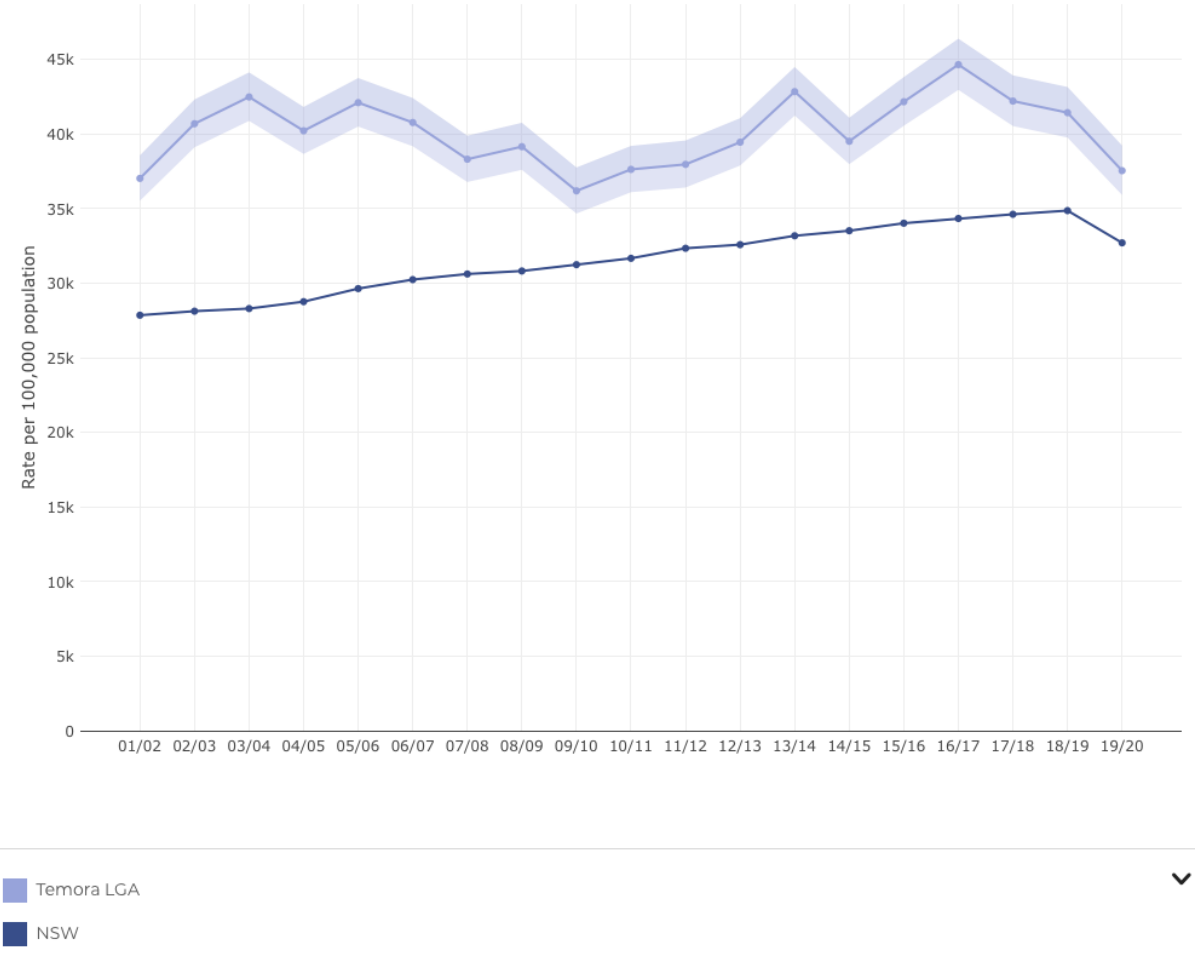


Source: Health Statistics NSW, current as of March 2022.

The average number of hospitalisations per year for residents of Temora LGA was around 3000 from 2013-14 to 2019/20. The age standardised rate was significantly higher than the rate for the rest of NSW for that year and all of NSW and rates have been steadily increasing since the early 2000's (Figure 10).

Hospitalisations for all causes by LGA

Figure 10: Hospitalisations trend Temora LGA 2001-02 to 2019-20



Note: The shaded area indicates the 95% confidence interval for the LGA rate – if it does not cross the NSW line it is significantly different from the NSW rate.

Source: Health Statistics NSW, March 2022.

Table 7: Hospitalisations for all causes, Temora LGA, NSW 2014-15 to 2018-19

Year	State comparison	Number	Rate per 100,000 population	LL 95% CI	UL 95% CI
15/16	NSW	2828349	34019.2	33979.0	34059.4
	Temora LGA	3148	42162.1	40557.1	43814.4
16/17	NSW	2912207	34337.0	34297.0	34377.1
	Temora LGA	3224	44649.8	42962.4	46386.0
17/18	NSW	2990128	34617.9	34578.1	34657.8
	Temora LGA	3028	42206.2	40536.6	43926.2

Year	State comparison	Number	Rate per 100,000 population	LL 95% CI	UL 95% CI
18/19	NSW	3067498	34865.2	34825.6	34904.9
	Temora LGA	2984	41430.1	39763.3	43148.3
19/20	NSW	2929756	32705.0	32666.9	32743.1
	Temora LGA	2755	37542.7	35917.1	39222.3

Source: Health Statistics NSW, March 2022

Morbidity – cancer

MLHD had significantly higher incidence of total cancers and deaths from all cancers, lung, and prostate cancer in MLHD compared to NSW (2013-2017). Temora had a high incidence of prostate cancer compared to NSW (Table 8).

Table 8: Cancer incidence and mortality by LGA compared to NSW (2013-2017)

	LGAs with significantly higher rates than NSW	
Cancer type	Incidence (new cases)	Deaths
Bowel	Greater Hume, Snowy Valleys	Greater Hume and Hilltops
Breast	Cootamundra-Gundagai	Cootamundra-Gundagai
Prostate	Bland, Carrathool, Gundagai, Hilltops, Narrandera, Snowy Valleys, Temora & Wagga Wagga	Bland
Lung	Junee, Carrathool, Edward River, Federation	
Skin	Bland, Lockhart (low in Griffith)	
Pancreatic	Snowy Valleys	

Source: Cancer Institute NSW, March 2022.

Health Related Behaviours

The MLHD population has higher prevalence of many lifestyle health risk factors than NSW averages including smoking, alcohol consumption and being above healthy weight (Table 9).

Table 9: Lifestyle related health determinants, MLHD

Topic	Statistic	Compared to NSW (statistical significance)
Smoking	19.5% of adults smoke (MLHD 2020, 13.3% in NSW)	High
	14.3% of non-Aboriginal mothers had smoked during pregnancy (MLHD 2020; NSW 7.0%) compared to 49.1% of Aboriginal mothers (NSW 41.7%) a total of 17.6% of mothers (NSW 8.6%).	High
Alcohol	45.5% of adults drink alcohol at risk levels to health (MLHD 2020, significantly higher than NSW 32.5%)	High
Exercise	40.8% of adults reported insufficient exercise (NSW 2020, 38.3%)	
Diet	6.9% of adults reported adequate vegetable consumption (NSW 2020, 5.9%) and 43.5% reported adequate fruit intake (NSW 2020, 40.3%)	
Weight	70.3% of adults were above healthy weight (MLHD 2020, significantly higher than NSW 56.8%)	High
	35.3% of adults have obesity (MLHD 2020, significantly higher than NSW 22.5%)	High
Diabetes	16.6% of adults reported ever being diagnosed with diabetes (MLHD 2019; NSW 11.3%)	
Asthma	9.6% of adults (MLHD 2019: NSW 11.5%) and 20.5% of children (MLHD 2017-2019: NSW 13.1%) reported to have current asthma.	
High Blood pressure	30.9% of adults reported ever being diagnosed with High Blood Pressure (MLHD 2019, NSW 24.8%)	
High cholesterol	35.8% of adults reported ever being diagnosed with High cholesterol (MLHD 2019; NSW 29.5%)	

Source: Health Statistics NSW, March 2022.

For Temora

Major health issues for Temora LGA include smoking, chronic obstructive pulmonary disease and diabetes (Table 10).

Table 10: Hospitalisation Indicators for the Temora LGA

	Year	Average per year	Standardised Rate /100,000	NSW rate per 100,000	Higher or lower than NSW*	Trend in LGA Since 2005
All hospitalisations	2019-20	2755	37543	32705	**High**	Increasing
Potentially Preventable	2017-19	146.9	2439	2161	Not higher	Decreasing
Smoking attributable	2017-19	62.8	1127	659	**High**	Decreasing
Smoking during pregnancy	2017-2019	11.5 smoke / 66 mothers	18%	9%	**High**	Decreasing
Alcohol attributable	2017-19	33.4	555	514	Not higher	Increasing
High Body Mass attributable	2017-19	54.6	906	752	Not higher	Steady
Fall-related injury	2018-20	42	708	703	Not higher	Increasing
COPD	2017-19	24.6	409	230	**High**	Increasing
Coronary Heart Disease	2018-20	31.1	525	481	Not higher	Decreasing
Stroke	2018-20	9.0	152	134	Not higher	Decreasing
Dementia as principal diagnosis or co-morbidity (65+ yrs)	2018-20	27.5	1740	1661	Not higher	Decreasing
Asthma	2018-20	8.7	147	132	Not higher	Decreasing
Self-harm hospitalisation	2018-20	9.5	161	90	Not higher	Increasing
Diabetes as principal diagnosis	2018-20	31.7	268	159	**High**	Increasing
Diabetes as co-morbidity	2018-20	477.4	4034	156	**High**	Increasing

Source: Health Statistics NSW, accessed March 2022 *Based on 95% Confidence intervals around age-standardised rates per 100,000.

3. SERVICE MODEL

Temora Health Service is part of a Cluster management structure with Cootamundra Health Service, Gundagai MPS and Coolamon MPS. There is very little flow between these facilities; rather, patients are transferred to WWBH rather than between these sites when one or more are on *Critical Operations Standing Operating Procedures (COSOPS)*.

For the Temora catchment, Young is the closest District level hospital (C2) within MLHD providing a greater volume of services than either Temora or Cootamundra; however, Wagga Wagga as the Base Hospital for the District (B1) is relied upon where higher-level care for a patient is required. There are a number of A1 Principal Referral Hospitals that are accessed by Temora residents including Canberra Hospital and Health Services (2/12 hours' drive), and multiple Sydney hospitals.

Temora Health Service does not provide residential aged care but has strong links with the Whiddon Group -Temora and Whiddon Group - Greenstone services, both located in Temora.

4. NON-INPATIENT SERVICES - CURRENT

Description of Current Services

4.1 POPULATION HEALTH SERVICES

Temora is supported by a Public Health Unit, which covers MLHD and Southern NSW LHD as well as Albury. The following services are provided as part of Public Health services:

- Environmental health.
- HIV, Sexual Health, and Hepatitis services.
- Immunisation services.
- Infectious disease monitoring and reporting.
- Tobacco Compliance; and
- Tuberculosis services.

Most of these service professionals are based at the MLHD Albury Office. Public Health support and advice for health professionals is available 24 hours per day, 365 days per year.

A Needle and Syringe Program (NSP) service operates from the Temora Emergency Department as well as via a free automatic dispensing machine with 24-hour access.

Access to HIV and STI testing, and treatment services are available Sexual Health Service (Brookong Centre) located at Wagga Wagga Health Service hub is the closest point for Temora residents.

Access to Hepatitis C treatment services is through local GPs and the Hepatitis C treatment Service in Wagga Wagga. There is also remote consultation and support for GPs across the District.

4.2 ABORIGINAL HEALTH SERVICES

In 2016, 2.8% of the population of Temora identified as Aboriginal and/or Torres Strait Islander[20]. There are several key strategic partners such as the District Wide Aboriginal Health Consortium who bring important service connections to the Aboriginal Health Service[21].

The Aboriginal Health team provides a variety of services to inpatients and community members, including emotional, practical, and social and welfare support and health education opportunities for Aboriginal people and communities.

In addition to providing inpatient support to Aboriginal people and their families, the Aboriginal Health Service also delivers a number of community-based programs which have a focus on achieving more equitable health outcomes for Aboriginal individuals and communities[22].

[20] The Murrumbidgee summary population health indicators 2022
[21] Wagga Wagga Health Service Aboriginal Health Service Model of Care July 2020 Revision 2 p 15
[22] Et al pp 8-9

Aboriginal Health Services are provided as an outreach service to Temora from the hub site at Tumut. Several programs and additional support services are available for people who identify as Aboriginal or Torres Strait Islander. These include availability of Aboriginal Health Workers for liaison/ support, and connection to Aboriginal health programs described below.

The main issues reported for people accessing health services were availability of transport, and attending without support, particularly for mental health services. Reluctance to go to hospital can be due to links with death or fear of death.

Specific programs provided by Aboriginal Health Services include:

- 48 Hour Follow Up - a comprehensive program that provides support to Aboriginal patients who are being discharged from hospital
- Aunty Jeans - a program delivered in community settings to support Aboriginal people with, or at risk of, chronic illness
- Otitis Media screening at schools and pre-schools - this program aims to reduce the number of children with hearing problems through regular screening and education
- Targeted Early Intervention- provides services to assist with delivering positive outcomes for families with children between the ages of 0-5 years, who have barriers to engage in routine early childhood screenings.

Source: Wagga Wagga Health Service Aboriginal Health Service Model of Care July 2020 Revision 2 pp 8-9

4.3 HEALTH PROMOTION SERVICES

There are health promotion programs provided through MLHD including falls prevention/physical activity leaders programs (Stepping On, Tai Chi, Gentle Exercise and school/preschool programs based on the Healthy Children's Initiative (Munch and Move and Live Life Well at School).

Most of these programs are run in a community/school setting rather than through the health service. The seven week Stepping On program for falls prevention has been run in Temora at least annually (generally around 15 people) for the last five years. This program is run in different communities at different times. It has a further follow up program run two months after the initial program. Health promotion also provides tobacco control and education programs through schools and businesses/organisations.

There are issues with access to space for group activities such as the Stepping On Program and Community Exercise groups. At present workers try to find free venues in the community, however these are very limited and not ideal. There is no space for group activity within the Health Service as a whole. Group work is a growing modality for general, cardiac, and pulmonary rehabilitation programs, and population health prevention and education programs.

4.4 COMMUNITY HEALTH SERVICES

Temora Health Service has a multidisciplinary Community Health and Mental Health/ Drug and Alcohol (MHDA) team. Generalist Community Health outreach is provided to Ariah Park, and Ardlethan. Centralised specialist support positions such as

Clinical Nurse Consultants (CNC's), and Nurse Practitioners (NP's) provide additional advice and support when required. CNC/ NP positions are generally based in Wagga Wagga.

A community MHDA team is centrally located in Temora and provides equitable access to surrounding communities including West Wyalong, Coolamon and Junee. These services are available across the lifespan, Child and Adolescent (CAMHS), Adults, and Older Person's (SMHSOP). Temora is a declared community mental health facility.

MHDA services are underpinned by a number of policy documents as follows:

- Transfer of Care for Consumers of NSW Health Mental Health Services (PD2019_045)
- Physical Health Care of Mental Health Consumers Guideline (GL2017_019)
- NSW Older People's Mental Health Services Service Plan 2017-2027 GL2017_022
- The Specialist Mental Health Services for Older People (SMHSOP) Community Model of Care (MoC) GL2017_003
- Shifting the Landscape for Suicide Prevention in NSW a whole-of-Government Strategic Framework for a whole-of-community response 2022-2027
- National Recovery Framework and NSW Health's commitment to the Equally Well consensus statement

The Specialist Community Mental Health and Drug & Alcohol Teams provide:

- **Assessment:** this is an interview with a mental health clinician to identify the consumer's needs, which may also include consultation with a psychiatrist.
- **Individual Care:** Following assessment, the mental health clinician will give information about available treatment options and reach an agreement with the consumer about a care plan. Other important people in the consumer's life may be involved in this process with the consumer's permission.
- **Case Management:** This is offered to consumers who require further counselling, treatment, or recovery support. This includes referral and consultation with other service providers.
- **Psychiatry Clinics**: Adult, Child and Adolescent and Older Persons Psychiatrists visit on a weekly basis
- **Referral and Consultation:** When the initial assessment has been completed it may be necessary to refer to (or consult with) other service providers for specialist services.
- **Education:** Education on a variety of mental health issues is provided to consumers, families, carers and community groups.
- **Advocacy:** The Community Mental Health Service can speak with other service providers on consumers' behalf.
- **Drug & Alcohol and Opioid Treatment program:** Aiming to reduce harm caused using drugs and alcohol. Responding to people with all kinds of use and patterns of harm, not just those with dependence. Offering education, assessment and referral to other specialised drug and alcohol services for

individuals, families, and community groups; This includes consultation with an Addiction Specialist

- **Carer Peer Support Worker and Consumer Peer Worker:** People with Lived Experience provide support and advocacy to consumers and carers
- **Mental Health Support Workers** work alongside the clinicians and support consumers with implementing their wellness plan
- **Got IT Program:** Screening and Intervention in Primary schools for children who may be vulnerable to MH issues in the future.

4.5 DENTAL SERVICES

Murrumbidgee Local Health District Oral Health Service operates with two models of care. The primary being for emergency, general, preventative care and oral health promotion provided by MLHD Oral Health Staff. The secondary being the Oral Health Fee For Service Scheme (OHFFSS) which allows Public dental services to outsource dental treatment for eligible adults to private practitioners who have applied to be a registered OHFFSS provider. Care provided through this scheme includes emergency/general care and all prosthodontic services. Vouchers for this scheme are issued on a limited basis as required, by MLHD Oral Health Services.

There are two private dental services in Temora (Alliance Dental Group, and St. Mary's and St. John's Medical and Dental Centre) who provide dental services for children and adults. Children 0- 17 years of age who are eligible for the Child Dental Benefits Scheme can elect to utilise the scheme administered by Medicare to access subsidised care with a private or public dental provider.

Public Dental Services unlike other health services are not covered by the principle of universal access. MLHD provides a public dental system offering a range of services to children as well as adults who meet the eligibility criteria outlined below.

All children under 18 years of age are eligible for general dental services. For adults to be eligible, they must hold or be listed as a dependent on one of the following valid Australian Government concession cards:

- Health Care Card
- Pensioner Concession Card (includes Centrelink and Department of Veteran Affairs)
- Commonwealth Seniors Health Care Card

In the past some public dental services have been available at the Temora Health Service. Due to the age and condition of the Temora dental clinic and ongoing clinical vacancies in the Griffith dental cluster the clinic is not currently utilised routinely.

Pending the facility being made compliant with the relevant Australian standards and recruitment to clinical vacancies, the dental clinic at Temora could again be utilised to provide public dental services for children and eligible adults.

4.6 NON-ADMITTED SERVICE SUMMARY

Community services available through MLHD for the Temora catchment are outlined in the table below.

Table 11: Temora Health Service – Current Community Health Services available

Profession/ Service	Core Activities	Frequency	Target Group	Predominant Setting
Audiologist	Consultation	1 day / month	Children, Youth, Young Adults	Community Health
Aged Day Care	Day Care	2 days / week	Adults	Day Care Centre
Aged Care Assessment Team (ACAT)	Consultation / Assessment	5 days / week	Not defined (by referral only)	Home or inpatient setting
BreastScreen Service - bus	Direct Clinical Service Delivery	Two yearly	women	Community setting
Child and Family Health Nurse	Care Coordination	5 days/ week	parents and children	Community setting
Cardiac Rehab Program	Group work	1 day/ week	Adults 65+	Outpatient setting
Chronic Disease Coordinator	Community work	As required	Adults 65+	Provided by Marathon Health
Clinical Nurse Educator	Consultation	4 days/ week	Service Providers	Workplace setting
Continence Service	Consultation	As required	Adults	Remotely – e.g. Telehealth / phone
Dementia services CNC DBAMS	Consultation	As required	Adults 65+	Based out of Wagga Yathong Lodge. Remotely – e.g. Telehealth / phone
Dental Service	Mixed activities	1 day/ week	Children and youth	Community Health
Diabetes Educator CNS	Mixed activities	1 day / month	Not defined	Community Health
Dietitian	Consultation	2 days/ week	Not defined	Community Health
Drug and Alcohol Services	Face to face consultation	5 days / week	Not defined	Community Health
Generalist community health nurse/s	Mixed activities Post-Acute Care	5 days / week	Adults	Community Health & home setting
Generalist Counsellor	Domestic Violence Counselling & Eating Disorders	5 days / week	Adults/Children affected by Domestic Violence	Community Health
GP service COAG 19(2) bulk billed emergency	Direct Clinical Service Delivery	As required	Not defined	Workplace setting
Health Promotion Officer	Mixed activities	As required	Not defined	Located in Young and Wagga Wagga
Immunisation child	Direct Clinical Service Delivery	Quarterly	children and youth	Schools

Profession/ Service	Core Activities	Frequency	Target Group	Predominant Setting
Mental Health Services – Specialist Child and Adolescent	Consultation/ Case Management	As required	children and youth 0-18yrs	Face to face, Community Health and Videoconference
Mental Health Services – Specialist Adult	Direct clinical and Consultation/Case management	As required	18 – 65yrs	Community Health, home setting and Remotely - e.g. Telehealth/ phone
Mental Health Services – Specialist Older Persons	Consultation/ Case Management	As required	65 + (or 45yrs + if Indigenous)	Community Health, home setting and Remotely - e.g. Telehealth/ phone
Mental Health Telehealth Psychiatry	Consultation	Minimum monthly and as required	Children, youth, Adults and older persons	Community Health and Telehealth
Mental Health Family and Carer Worker	Mixed activities	Minimum 1 day/ fortnight	Not defined	Based out of Wagga remotely – Telehealth and phone
Mental Health Consumer Peer Worker	Support of mental health consumers	Minimum 1 day/ fortnight	18-65 years Not defined	Community Health, home setting and remotely – Telehealth/phone Multiple settings
Suicide Prevention	Provides a virtual rapid crisis response to people experiencing situational crisis and/or suicidal distress	5 days per week from Thursday to Monday 1.30pm to 10.00pm	All ages	Staff are located in Griffith and Wagga A 'Virtual' service allows for SOT to provide a district response
Midwifery Educator	Mixed activities	1 day/ week	Service Providers	Workplace setting
Occupational Therapist	Direct clinical and consultation assessment, intervention and education	5 days / week	Adults	Inpatients, Community Health, Transitional Aged Care Packages (TACP)
Paediatric Care Coordinator	Care Coordination/ Care Navigation/ Health Coaching	3 days/week	Children with multiple complexities	MLHD service
Palliative Care Community Nursing	Community work	5 days/ week	Not defined	Community Health
Pathology	Pathology Collection	5 days / week (mornings only)	Not defined	Multiple settings
Physiotherapist	Direct clinical and consultation assessment, intervention and education	5 days/ week	Not defined	Inpatient, Community Health
Pulmonary Rehabilitation Program	Group work	As required	Other	Community Health
Radiographer	Direct Clinical	5 days/ week	Not defined	Workplace setting

Profession/ Service	Core Activities	Frequency	Target Group	Predominant Setting
	Service Delivery			
Speech Pathologist	Direct clinical and consultation assessment, intervention and education	2 days/ week	Not defined	Inpatient, Community Health
Stepping on program	Direct group work	7-week program quarterly	Adults 65 +	Community facility
Transitional Aged Care	Community work	5 days / week	Adults 65+ (recent inpatients)	Community setting
Venepuncture Emergency	Mixed activities	As required	Not defined	Outpatient clinic
Women's Health Nurse	Consultation	Monthly	Women	Community Health
Wound Management Community nursing, emergency	Mixed activities	As required	Not defined	Multiple settings
Child Sexual Assault Counsellor	Face to face consultation	1 day / month	Children/Youth	Community Health
Aboriginal Health Worker	Mixed activities	Outreach as needed	Aboriginal people	Multiple settings Telehealth

Source: Community Health Manager Temora

4.7 NON-ADMITTED PATIENT OCCASIONS OF SERVICE

N.B. The activity for 2018/19 has been used to demonstrate current service activity as the last reliable year of data as there were drops in activity in 2019/20 as a result of the COVID-19 pandemic.

Temora Health Service non-admitted services activity shows a slight decrease in the five years from 2016/17 to 2020/21 (-0.2%). It must be noted that Non-Admitted Patient Occasions of Service (NAPOOS) data is not reliable as an indicator of need; rather it shows what has been provided.

Staff vacancies can lead to variable activity in some programs, which skews any analysis of community need for services. Over time there have been reporting changes between service units within programs. This can show gaps for some service units where activity in now being allocated differently. The data is unreliable as a basis for projecting future need.

As well, the NAPOOS data for Temora has some significant gaps due to reporting line changes for some programs and the introduction of CHOC (Community Health Outpatient Clinic) reporting software.

In 2020/21, Pathology had the largest proportion of NAPOOS (14.2%), followed by Rehabilitation (10.4%), Post-Acute Care (9.6%), Alcohol and Other Drugs (9.3%), Primary Health Care and Physiotherapy (7.4%), General Imaging (6.8%) and Hospital Avoidance Program (5.5%). Other Tier 2 programs made up the remaining 33.4%.

Table 12: Temora Hospital NAPOOS activity by Tier 2 Program and Service Name 2016/17 to 2019/20

Teir 2 Program Name	Service Name	2016/17	2017/18	2018/19	2019/20	2020/21	% Of Total
Pathology	Temora Health Service ED Pathology Service	764	1,058	1,024	1,182	2,079	14.2%
Rehabilitation	Temora Health Service Transitional Rehabilitation Aged Care Service	2,449	1,909	2,790	1,977	1,526	10.4%
Alcohol and Other Drugs	Temora Health Service Drug and Alcohol Service	819	620	494	1,123	1,368	9.3%
Primary Health Care	Temora Community Health Service Child & Family Service	1,076	1,323	1,447	1,206	1,087	7.4%
Physiotherapy	Temora Health Service Physiotherapy Clinic	50	1,152	1,767	1,284	1,081	7.4%
Post Acute Care	Temora Health Service Nursing Post-Acute Care	144	554	1,440	1,689	1,399	9.6%
General Imaging	Temora	1,077	1,063	1,280	1,158	992	6.8%
Hospital Avoidance Programs	Temora Health Service Nursing Commonwealth Home Support Program	1,891	2,063	732	584	809	5.5%
Other		5,607	3,472	4,843	4,539	4,884	33.4%
Total		**13,877**	**13,214**	**15,817**	**14,742**	**14,635**	

Source: Temora Utilisation Report prepared by MLHD Performance Team

In 2020/21, Minor Medical Procedures had the largest proportion of NAPOOS (27.9%), followed by General Imaging (17.5%), Acute Post-Acute Care (APAC) (16.2%), Pathology (12.7%) and Aged Care Assessment (5.1%).

The service with the biggest annual increase during this time was Physiotherapy Clinic (137.5%), followed by Nursing Post-Acute Care (58%), Pathology Services (11.5%) and Drug and Alcohol Services (4.5%).

Table 13: Temora Hospital NAPOOS activity 2016/17 to 2019/20 per annum increase (%)

NON ADMITTED OCCASIONS OF SERVICE (NAPOOS)	2016/17	2017/18	2018/19	2019/20	2020/21	Increase per annum (%)
Temora Health Service Transitional Rehabilitation Aged Care Service	2,449	1,909	2,790	1,977	1,526	-2.5%
Temora Health Service Nursing Post-Acute Care	144	554	1,440	1,689	1,399	58.1%
Temora Health Service Drug and Alcohol Service	819	620	494	1,123	1,368	4.5%
Temora Community Health Service Child & Family Service	1,076	1,323	1,447	1,206	1,087	0.1%
Temora Health Service Physiotherapy Clinic	50	1,152	1,767	1,284	1,081	137.5%
Temora Health Service Nursing Commonwealth Home Support Program	1,891	2,063	732	584	809	-3.8%
Other	7,448	5,593	7,147	6,879	7,365	-0.1%
TOTAL NAPOOS	**13,877**	**13,214**	**15,817**	**14,742**	**14,635**	**0.4%**
Imaging Services	1,458	1,611	1,599	1,502	1,311	-0.7%
Pathology Services	764	1,058	1,024	1,182	2,079	11.5%
SUBTOTAL	2,222	2,669	2,623	2,684	3,390	3.5%
TOTAL NAPOOS (excluding Radiology and Pathology)	**11,655**	**10,545**	**13,194**	**12,058**	**11,245**	**-0.2%**

Source: Temora Utilisation Report prepared by MLHD Performance Team

Temora Health Services Community Adult Mental Health Services provided a total of 60,536 client contact occasions in the five years 2018 to 2022; this equates to an average of 12,107 client contact occasions per annum. Of these, 7,397 or 12% were telephone, telemedicine, or video link consultations and a further 2413 or 4% were face to face.

Table 14: Temora Health Service Community Mental Health Services activity 2018 to 2022 per

Row Labels	2018	2019	2020	2021	2022	Grand Total
TE Adult	11,239	7,276	8,897	10,029	9,508	46949
TE CAMHS	1,642	1,878	2,180	2,465	2,799	10964
TE Older People	974	617	252	322	55	2220
TE Peer STOC			1	1	5	7
TE Vulnerable Populations				1	339	340
TE Assertive CAMHS				24	23	47
TE Farm Counselling					9	9
Grand Total	**13855**	**9771**	**11330**	**12842**	**12738**	**60536**

Source: CHOC CMH029 – Client Contact Report 01/07/2018 to 31/05/2022

The Child and Adolescent Mental Health Service Program had a significant increase in NAPOOS in the five years (70%) whilst the Adult and Older People programs showed a decline in service activity.

5. NON-ADMITTED SERVICES- PROPOSED

Future Models of Care

There are opportunities to streamline non-inpatient services to improve efficiencies, better integrate services, and provide a service based around client needs.

Future direction for all Health Services requires a change of mindset to see the community or appropriate ambulatory setting as the natural location for most health care, with hospital admission or Emergency Department presentation as the alternative if the illness.

- is severe
- requires surgery
- requires higher technology or
- requires urgent, rapid, or more intensive assessment, therapy & care which cannot be provided in the community or ambulatory setting.

Adopting new ways of working, new models of care, better care coordination and integration will help improve access, reduce avoidable admissions, ensure service equity and make better use of the available workforce[23].

Non-Admitted Services is the overarching term for a range of services including:

1. Outpatients

A service provided to patients who do not undergo a formal admission process and do not occupy a hospital bed (NSW Health, 2019, 10).

The classic outpatient service operates on an allocated session /scheduled basis. The service will provide scheduled clinics for a range of clinical services as well as specialist follow-ups. It is proposed that Temora will provide a number of clinics including but not limited to:

- medical and surgical
- Ante natal and post-natal
- Acute Post-Acute Care services
- Adult HiTH
- Allied Health
- fracture clinics
- wound care
- child and family
- mental health
- drug and alcohol

The clinics will be operated within normal business hours i.e., Monday to Friday 0800 to 1700 hours, however consideration will need to be made for extended hours (i.e., 0700-2100 and weekend consultations) in the near future.

N.B. Acute Post-Acute Care (APAC) is an acute service which treats many conditions in the patient's home that would otherwise have meant being admitted to

[23] *Western NSW Integrated Care*

hospital. The service can be provided by either hospital staff or community health staff.

2. Hospital Avoidance

This is a service that is utilised as an ED avoidance strategy. Examples include:

- Urgent review and drop in clinics
- by specific appointment given after telephone consult
- education sessions or group sessions e.g., Diabetes Education Sessions; Antenatal Classes
- direct referrals to specialist teams for chronic and complex patients by phone or Virtual Care
- care coordination/management
- GP liaison
- Adult HITH and Rehabilitation in the Home (RITH)

These services may be led by a general medical/advanced nursing member who could assess a patient post ED discharge or hospital discharge and refer to appropriate teams or an Integrated Care model with PHN liaison.

3. Infusion Service

The infusion service provides therapy which mainly consists of administration of day only infusions for several therapeutic agents including blood transfusions, iron infusions, monoclonal antibody preparations, methylprednisolone, immunoglobulin etc.

4. Allied Health Services

All allied health services will provide a mix of hospital inpatient, in-reach and community-based services. It is proposed that a large majority of allied health services will be local to allow staff to service both the hospital and the community. These will be a combination of face to face and Virtual Care.

Allied health services will provide a range of services including:

- Dental
- Dietetics
- Occupational Therapy
- Physiotherapy
- Podiatry
- Social Work
- Speech Pathology

5. Community Health/Hospital in the Home

Community Health will continue to run the range of services outlined previously in the current services section. As well there is an increasing need for post-acute care services and adult Hospital in the Home (HiTH) services to be expanded and enhanced in the future as a hospital avoidance/ED avoidance strategy.

HiTH provides short home-based care as a substitute for people who would otherwise be admitted to a hospital. HiTH provides acute, sub-acute and post-acute care to a person at home (including Residential Aged Care Facilities) or in an ambulatory setting that may include a hospital or community clinic, school or workplace.

HiTH is largely a nurse run service but will also have Medical, Allied Health including Pharmacist and Social Work support when required. There are opportunities to rotate staff between smaller and larger sites to develop their skills. This will develop expertise in HiTH models and increase the skills mix of staff.

HiTH services will be centrally managed with Hubs due to the large geographical area. HiTH is resource intensive and expensive to run. Temora Health Service will provide onsite care assessment, with nurses providing in-home care from centres in Cootamundra, Coolamon and Gundagai.

Referral pathways will be developed to enable Medical Officers, Allied Health, General Practitioners and Nurse Practitioners to make appropriate referrals to the service.

Wound management and peripherally inserted catheter maintenance will in the main, be delivered in the outpatient setting. Service delivery in the home setting will continue for some client groups i.e., the elderly or immunocompromised clients.

Patients have antibiotics at home and are monitored virtually with nurse visits as required. Currently, these are administered as Baxter IV antibiotic kits. There are currently 2 -3 admissions daily for IV Antibiotics. Patients with post-operative wound infections including complicated wound infections would be admitted to HiTH for ongoing management.

The NSW Health Outpatients Services Framework provides guidance on the expectations of the NSW Ministry of Health for the planning, progressions and management of outpatient services, and outlines clear goals and targets to which outpatient's service units can work towards[24].

5.1 WELLNESS CENTRE - AMBULATORY/ OUTPATIENT/ COMMUNITY HEALTH

There is a vision for a wellness centre that will collocate non-admitted patient services such as clinics, procedural, allied health therapy, rehabilitation, and community health/ mental health and drug and alcohol clinical/consultation services. Group services would also be delivered as part of this wellness model. Garden areas to spill out from group activity spaces were highlighted as important for the Aboriginal community.

From an Aboriginal perspective, consultations indicated that it is important for community health, outpatients and ambulatory services to have a separate presence and entrance, while still linked internally. This is to disassociate the service from death and dying, which is generally associated with the hospital and can impact on people accessing services.

[24] NSW Health: The Outpatient Services Framework 30 July 2019

Virtual Care models will be an increasing component of delivering a broader range of specialty services to the community.

The Wellness Centre model supports existing workforce requirements, particularly for allied health staff that have responsibilities across community, outpatient and inpatient groups. The model will assist with recruitment of allied health staff.

The model will require clinical support services such as radiology, pathology and pharmacy to be readily accessible.

MLHD Central Intake services have centralised the intake process, improved models of care, prioritised programs, and targeted service delivery. The Community Health Outpatient Clinics (CHOC) software will improve the reliability of non-admitted patient data in the future.

Governance for services that traditionally sat with community health has been streamed across MLHD. Collocation of these services, with good links to inpatient and support areas is therefore critical for ongoing integration of services for better patient outcomes.

Drug and alcohol services were highlighted in consultations as an area of growth. A flow on to community support services is anticipated. Future service models will need to meet this demand while maintaining safety for clients and practitioners.

Projected Activity

Clinic spaces have been determined based on patient throughput. If each patient session was for 30 minutes, each space operates for 7 hours a day, 240 days a year at 80% occupancy; each space could accommodate 2,688 NAPOOS per year. For mental health patient sessions are calculated at 60 minutes each and equate to each space accommodating 1,344 NAPOOS per year.

In 2021, there was a total of 14,635 general and 12,842 mental health NAPOOs provided at Temora Hospital. Pathology and radiology are excluded from projected clinic space requirements as are home, other and inpatient settings. Group and non-face to face/ video are also excluded for the purposes of projecting clinic spaces. Projections are based on historical average annual increases over the past four years, noting increases are consistent with recommendations in the NSW Future Health strategy to provide more services in non-inpatient settings, and the increased funding for community mental health services.

Table 15: Temora Hospital proposed increase in NAPOOS activity 2021 to 2036*

Year	2021	2026	2031	2036
Number of general NAPOOS with exclusions	6254	10973	19251	33776
Number of Mental Health NAPOOS with exclusions	1623	4134	6811	11221
Number of general Clinic Spaces	2.3	4.1	7.2	12.6
Number of Mental Health Clinic Spaces	0.9	3.1	5.1	8.3
Total Clinic Spaces	**3**	**7**	**12**	**21**

Source: Temora Utilisation Report prepared by MLHD Performance Team and MH report by MH data custodians
*Exclusions include group sessions, some service contact modes (postal/SMS, email, no client contact), and some setting types (home, other, inpatient).

It is estimated that clinic based NAPOOs will increase by 208% to 19,251 NAPOOS by 2031, and by 320% for mental health NAPOOs to 6,811. This represents an increase in clinic spaces required to 7 spaces by 2026, and 12 spaces by 2031. However, the above projections exclude activity provided by visiting clinical nurse consultants, nurse practitioners, allied health specialists, or medical specialists due to activity for these positions being allocated to the cost centre where the provider is based. There is also a need for space for the community to access virtual care technology if unavailable in the home.

State and MLHD strategic directions to increase non-inpatient care will continue to see a growth in outpatient and community health clinic activity. To accommodate the underestimated current use and future directions it is proposed the following spaces are included in the built capacity:

- 2 x consult/interview rooms to enable community to access virtual care technology if no computer or connectivity in the home. Will require appropriate technology for a range of consultation types. Can also be used as consultation rooms to accommodate visiting specialists.

Facility Requirements

It is envisaged that the entrance to the wellness centre will be front of house to clearly establish the focus on prevention, early intervention, and health maintenance models. Advice has been forthcoming to improve cultural safety including welcoming staff (those consulted felt the hospital currently does this well), Aboriginal artwork and flags, and involvement of the Aboriginal community in cultural enhancements.

Appropriate facilities for rehabilitation services will be provided in the Wellness Centre for use by both inpatients and outpatients. This will include therapy areas such as a gym and an ADL area that could double as a support area for clients attending the outpatients/ambulatory zone, a large group room that can be used for hospital and community activities as well as access to outpatient clinics.

Mental Health & Drug and Alcohol services have many staff (15 FTE at present) and require access to a community services hub with shared space for on-the-spot support as well as discrete, quiet spaces for patient consultations and staff Huddle meetings. Patients attending MH&D&A clinics require quiet spaces for waiting and access to outdoor areas. All consult rooms/clinic spaces used by MH&D&A require dual access.

Dental services will require appropriate spaces for clinical (one chair), education, sterile stock storage and office accommodation. The service needs to be child safe, with sub-wait facilities to accommodate parents with other children, but also accommodate adult clients (scheduled on separate days). The space can be used flexibly when not in use by dental.

Staff education and meeting spaces are required to accommodate ongoing education needs and collaborative meetings for staff in both the inpatient and non-inpatient arena. Staff Appropriate accommodation facilities for staff located in the Wellness Centre will also need to be addressed. The MH&D&A teams require their own neighbourhood with good acoustic separation from others to enable established

model of care requirements for frequent discussion and liaison between staff in this space.

The above clinic calculations exclude spaces for Specimen Collection and areas for minor procedures, infusions, and wound dressings. It also does not include spaces for community to access virtual care technology and space for remote outpatient consultations. Appropriate staff office space and facilities will be required to accommodate staff in the Wellness Centre.

It is proposed that Wellness Centre will incorporate:

- 12 X mix of consult/ treatment/interview rooms for outpatient/ community health clinics (including a minimum of 1-2 treatment/procedure spaces to accommodate HiTH, infusions, wound dressings etc)
- 2 virtual care consult/interview spaces for community to access for virtual care and visiting specialist staff to use
- Rehabilitation therapy areas including 1 X gym
- 1 X group room for cardiac/pulmonary rehab and other large group physical activity-based programs
- ADL kitchen and laundry (may be on ward area)
- Dental clinic (1 chair) with education, stock storage, staff workstation and sub-wait for families with other children in a child safe environment
- Outdoor garden space with mobility areas
- 1 x specimen collection
- Staff office accommodation
- Space for staff education and meetings

6. EMERGENCY AND INPATIENT SERVICES - CURRENT

6.1 EMERGENCY SERVICES

Description of Current Services

Emergency services (ED) at Temora Health Service currently operate at RDL 2 with a range of medical and surgical patients as well as mental health, cognitively impaired and the occasional paediatric patient.

The ED has the capacity for triage and MHECS. Telehealth is part of the model for bedside critical care advice and support through the Patient Flow Unit. The service is linked with WWBH as well as Griffith and Tumut Hospitals.

The MLHD Critical Care Advisory Service provides support and clinical backup for patients presenting to ED. Critical care cameras above ED beds provide visibility of the patient by the remote critical care team and communication with local staff is through headsets to allow for hands free care to be delivered25.

The NSW Critical Care Tertiary Referral Networks & Transfer of Care (Adults) Network also provides support to EDs to manage patients who are critically ill or injured and those patients at risk of critical deterioration requiring referrals and transfer of care[26].

The current ED requires a total upgrade as it is tiny and cramped as well as having major issues relating to patient and staff flows, adjacencies and basic layout. The standard components of a contemporary emergency department are also absent.

Skill maintenance of staff is an ongoing issue, particularly with the generalist model requiring staff to work across inpatient, perioperative, maternity and emergency care.

Current Activity

Current activity in the ED over the last five years indicates presentations ranged from 3,819 presentations in 2018/19 to 4,280 presentations in 2017.18. This indicates that over the four years there was an average of 4,077 presentations per year. This related to an average of 11 presentations per day over the four years. Total presentations during these four years have remained reasonably stable.

N.B. There was a noted drop in presentations in 2019/20, which was impacted by the COVID-19 pandemic.

Table 16: Current Emergency Department Activity at Temora Hospital 2015/16 to 2019/20

Triage Category	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020
1	10	15	9	8	5
2	235	210	213	257	215
3	681	827	777	853	982
4	1,422	1,293	1,346	1,249	1,289
5	1,701	1,812	1,934	1,447	625
N\A	1	2	1	5	
Total	**4,050**	**4,159**	**4,280**	**3,819**	**3,116**

Source: CaSPA EDAA20

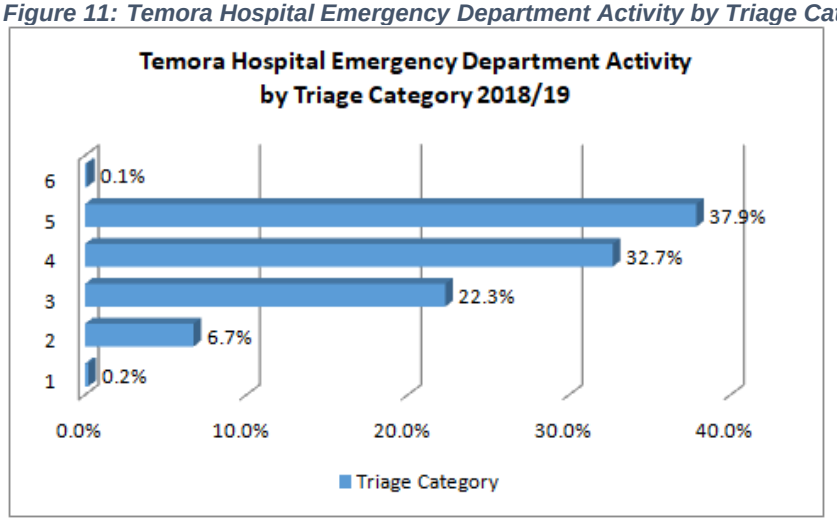
[25] MLHD Draft Clinical Services Framework 2021-2026 p. 41
[26] NSW Health Critical Care Tertiary Referral Networks & Transfer of Care (Adults) PD2010_021 Publication date 30-Mar-2010

On presentation to an ED, patients are triaged according to the urgency of care need. This ranges from Category 1 – patients with conditions that are life threatening and require immediate aggressive intervention - to Category 5 –patients with chronic or minor illnesses where clinical outcome will not be significantly affected if treatment is delayed for up to two hours.

N.B. The activity for 2018/19 has been used to demonstrate current service activity as the last reliable year of data as there were drops in inpatient and ED activity in 2019/20 because of the COVID-19 pandemic.

In 2018/19 at Temora Hospital, most presentations were for Triage Category 5 (37.9%); followed by Category 4 (32.7%), Category 3 (22.3%), Category 2 (6.7%) and Category 1 (0.2%). This pattern is reflected across the five-year period.

Figure 11: Temora Hospital Emergency Department Activity by Triage Category 2018/19



Source: CaSPA EDAA20

In 2018/19, of the number of presentations, approximately 87% were not admitted to a hospital for ongoing treatment and management of their condition i.e., were discharged home.

Table 17: Patients attending Emergency Department at Temora Hospital 2015/16 to 2019/20 who were admitted or not admitted

Is Admitted	015/201	2016/2017	2017/2018	2018/2019	2019/2020
No	3,194	3,360	3,694	3,324	2,597
Yes	856	799	586	495	519
Total	**4,050**	**4,159**	**4,280**	**3,819**	**3,116**

Source: CaSPA EDAA20

Most of the patients presenting to ED in 2018/19 were in the 16 to 44 years and 45 to 69 years (33% and 26% respectively), followed by 0-15 years (20%) and 70 to 84 years (16% each).

Table 18: Patients attending Emergency Department at Temora Hospital 2015/16 to 2019/20 by age group

Age Group	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020
0 to 15 Years	801	776	725	773	570
Not Recorded				1	
16 to 44 Years	1,568	1,335	1,318	986	889
45 to 69 Years	1,001	1,353	1,500	1,250	859
70 to 84 Years	470	522	553	627	565
85 Years and Over	210	173	184	182	233
Total	**4,050**	**4,159**	**4,280**	**3,819**	**3,116**

Source: CaSPA EDAA20

In 2018/19, the majority of presentations occurred on Sunday (21.9%) and Saturday (18.5%) i.e., 40.4% of all presentations.

Table 19: Patients attending Emergency Department at Temora Hospital 2015/16 to 2019/20 by day of the week

Day of the Week	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020	2018/19
Sunday	894	871	883	835	682	21.90%
Monday	517	566	579	498	396	13.00%
Tuesday	461	529	500	449	326	11.80%
Wednesday	495	496	511	423	378	11.10%
Thursday	407	486	514	429	402	11.20%
Friday	488	486	518	479	357	12.50%
Saturday	788	725	775	706	575	18.50%
Total	**4,050**	**4,159**	**4,280**	**3,819**	**3,116**	100.00%

Source: CaSPA EDAA20

In 2018/20, most presentations (85%) occurred between the hours of 9am to 9pm.

Table 20: Patients attending Emergency Department at Temora Hospital 2015/16 to 2019/20 by hours of the day

Hour	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020
9	203	212	234	205	184
10	294	363	446	386	205
11	472	546	772	528	229
12	193	204	220	188	167
13	209	195	222	188	188
14	306	326	300	326	250
15	211	212	198	188	142
16	224	226	191	152	175
17	213	217	185	174	169
18	236	244	213	218	205
19	232	243	226	222	180
20	231	245	202	197	202
21	156	184	160	169	154
	3,180	3,417	3,569	3,141	2,450
Other	870	742	711	678	666
Total	**4,050**	**4,159**	**4,280**	**3,819**	**3,116**

Source: CaSPA EDAA20

In 2018/19 most presentations were classified as emergency presentations (75.8%) followed by outpatient clinic presentations (21.7%). This represented a total of 97.5% of all presentations.

Presentations to the ED are classified as emergency, outpatient clinic, return visit p planned, pre-arranged admissions or 'other'. This is not reflective of their triage category, although the majority of non-emergency presentations will be in the lowest categories. In 2018/19 the majority of presentations were classified as emergency presentations (92%).

It is worth noting that the number of Return visit – planned presentations decreased dramatically from 522 presentations in 2015/16 to 39 presentations in 2018/19 (-93%); whilst the number of outpatient clinic visits increased from 186 presentations in 2015/16 to 1,140 presentations in 2017/18 (513% or 256% per annum) with a slight dip in numbers in 2018/19 and a corresponding increase in emergency presentations.

Table 21: Patients attending Emergency Department at Temora Hospital 2015/16 to 2019/20 by type of presentation

Visit Type Name	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020
Current Admitted Patient Presentation	3	1		2	4
Dead On Arrival	1	5	3	3	3
Disaster	4	3	3	4	2
Emergency Presentation	3,223	3,159	2,981	2,893	2,768
Outpatient Clinic	186	784	1,140	827	278
Person in transit	5	2	4	6	2
Pre-arranged Admission: With ED Workup	51	5	7	5	6
Pre-arranged Admission: Without ED Workup	43	27	23	23	34
Return visit - Planned	522	121	69	39	12
Telehealth Presentation			1		
Unplanned Return Visit for continuing condition	12	52	49	17	7
Total	**4,050**	**4,159**	**4,280**	**3,819**	**3,116**

Source: CaSPA EDAA20

6.2 Inpatient Services

Description of Current Services

Acute inpatient services at Temora Hospital currently operate at RDL 2 - 3 for a range of medical, surgical and maternity services. Paediatric patients are managed as part of the MLHD paediatric tiered networked service with pathways and policies in place to guide transfers and management of paediatric patients. There are no planned inpatient admissions for paediatric patients, with the service currently provided at a level 2 role delineation (observation and stabilisation pending possible transfer; may be up to 48 hours following paediatrician consultation).

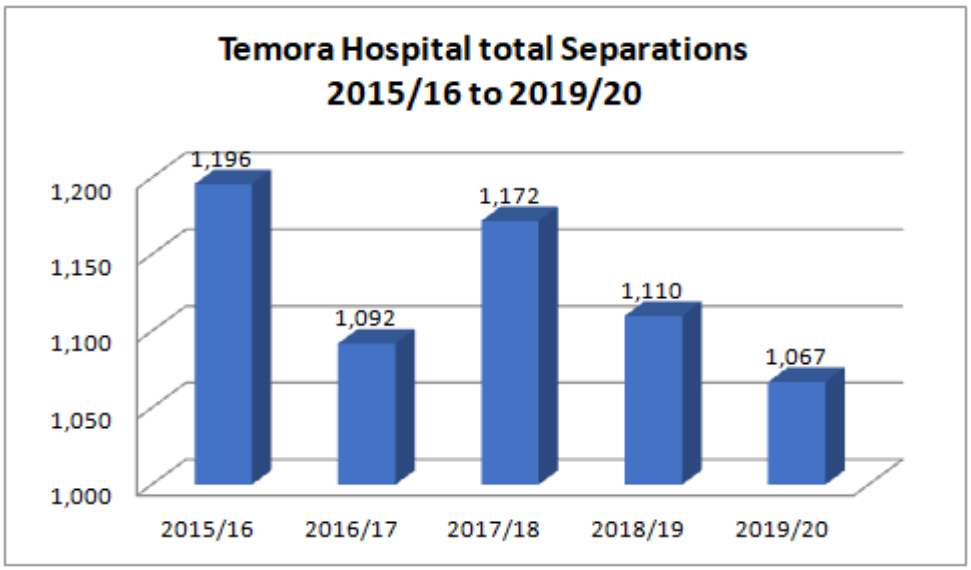
Sub-acute services currently operate at a RDL 2. This includes Rehabilitation and Palliative Care Services as well as Maintenance Care. Maintenance type care is indicative of people being admitted for longer lengths of stay, potentially related to chronic conditions or, post-surgical or medical admissions from higher level services.

Temora Hospital has a total of 28 inpatient beds (22 general and six maternity).

Current Activity (Acute)

Current acute inpatient activity indicates that there was an average of 1,127 separations at Temora Hospital in the five years 2015/16 to 2019/20 with slight peaks in activity in 2015/16 and 2017/18.

Figure 12: Temora Hospital Inpatient Activity 2015/16 to 2019/2020



Source: CaSPA FlowInfo V20 - Includes: all LGAs, Excludes: chemotherapy, renal dialysis, ED only, HiTH only and unqualified neonates

N.B. The activity for 2018/19 has been used to demonstrate current service activity as the last reliable year of data as there were drops in inpatient and ED activity in 2019/20 because of the COVID-19 pandemic.

In 2018/19, there were 1,025 separations at Temora Hospital which accounted for a total of 3,679 beddays. Most of the activity was overnight with 87% of separations and 97% of beddays. This equated to a total of 8.5 beds with 7.6 beds for overnight activity and 0.9 beds for day only activity. This activity would indicate that the occupancy rate for the inpatient bed capacity in 2018/19 was 36% based on the current bed stock of 28 beds.

The average length of stay for overnight activity was 4.1days. Overnight activity accounted for most separations (87%) and beddays (9%).

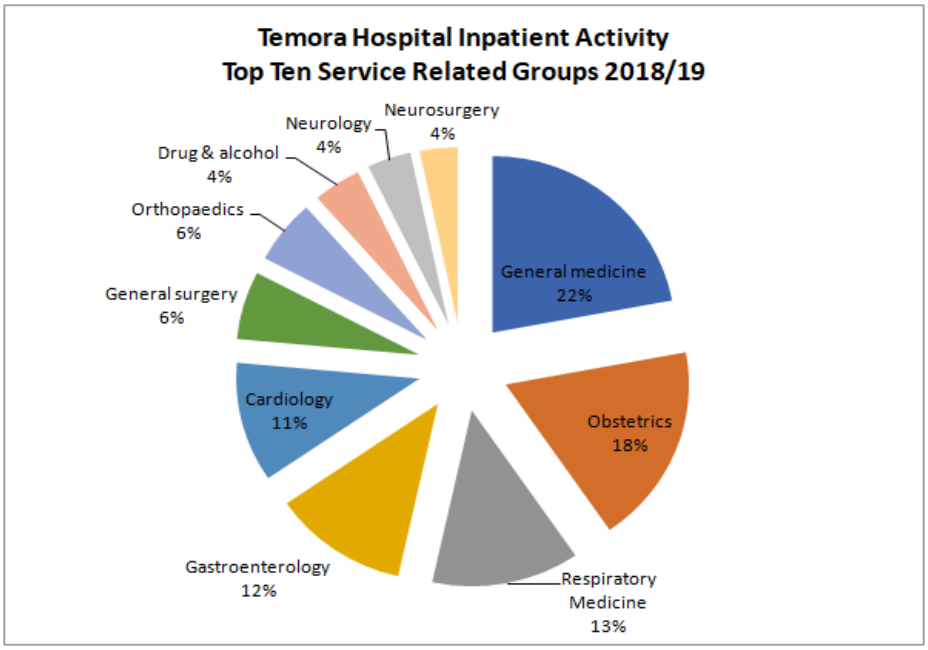
Table 15: Current Inpatient Activity at Temora Hospital 22015/16 to 2019/2020 overnight/day only split

Day Only Name	Values	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020
Day only	Total Separations	205	176	158	133	158
	Total Bed Days	205	176	158	133	158
Overnight(s)	Total Separations	943	865	963	892	872
	Total Bed Days	3,633	3,185	3,412	3,679	3,892
Total Separations		1,148	1,041	1,121	1,025	1,030
Total Bed Days		3,838	3,361	3,570	3,812	4,050

Source: CaSPA FlowInfo v20 - Includes all LGAs, Excludes ED only, HiTH only, chemotherapy, renal dialysis and unqualified neonates

In 2018/19, the top ten SRGs making up a total of 72% of total activity were General Medicine (22%), Obstetrics (18%), Respiratory Medicine (13%), Gastroenterology (12%), Cardiology (11%), General Surgery (6%), Orthopaedics (6%) and Drug and Alcohol, Neurology and Neurosurgery (4% each).

Figure 13: Temora Hospital Top Ten SRGs for Acute Inpatient Activity 2018/19



Source CaSPA FlowInfo V20
Includes all residents, all ages, all SRGs treated at Temora Hospital

Current Activity (Sub-Acute)

In 2018/19, there were 68 separations at Temora Hospital which accounted for a total of 992 beddays. This equated to a total of 3.6 beds. The average length of stay was 13.6 days.

Table 16: Temora Hospital Sub Acute Inpatient Activity 2018/19

SRG	Separations	Bed Days	Beds
Rehabilitation	18	237	0.9
Palliative Care	20	148	0.5
Maintenance	24	540	2.0
Geriatric Evaluation and Management	6	67	0.2
TOTAL	**68**	**992**	**3.6**

Source: CaSPA FlowInfo V20
Includes all ages, all SRGs, all resident LGAs treated at Temora Hospital

Inpatient Service Use Elsewhere

In the five years 2015/16 to 2019/10 demand for inpatient services for residents in Temora and the surrounding areas remained constant with an annual average of 21,906 separations.

Table 17: Residents of Temora and surrounding areas demand for inpatient services by LGA 2015/16 to 2019/20

	2015/16		2016/17		2017/18		2018/19		2019/20	
Resident LGA	**Seps**	**Bed Days**	**Seps**	**Bed Day**	**Seps**	**Bed Day**	**Seps**	**Bed Day**	**Seps**	**Bed Days**
Bland (A)	2,575	9,488	2,691	9,198	2,563	8,075	2,633	8,171	2,299	7,386
Coolamon (A)	2,167	6,532	2,156	5,977	2,170	6,389	1,877	5,536	1,820	5,544
Gundagai (A)	5,582	16,694	6,121	18,817	5,941	17,641	6,190	18,297	5,500	17,102
Hilltops (A)	5,911	21,498	6,424	24,124	6,387	22,466	6,249	21,457	6,080	22,103
Junee (A)	2,282	7,732	2,407	6,891	2,564	8,144	2,606	8,184	2,494	7,717
Temora (A)	2,775	8,315	2,884	7,921	2,817	8,186	2,747	8,902	2,621	8,448
Total	**21,292**	**70,259**	**22,683**	**72,928**	**22,442**	**70,901**	**22,302**	**70,547**	**20,814**	**68,300**

Source: CaSPA FlowInfo v20
Includes all hospitals
Excludes ED only, unqualified neonates, renal dialysis, chemotherapy

Most of the demand for services provided elsewhere was for acute services (92%).

In 2018/19, the top ten SRGs making up 66.3% of total demand activity were General Medicine (9.3%), Gastroenterology (8.4%), Orthopaedics (8.3%), Urology (7.2%), Respiratory Medicine (6.7%), Diagnostic GI Endoscopy and General Surgery (6.2%), Cardiology (5.3%), Ophthalmology (4.6%) and Obstetrics (4.1%).

Table 18: Residents of Temora and surrounding areas demand for inpatient services by SRG 2015/16 to 2019/20

SRG	2015/16	2016/17	2017/18	2018/19	2019/20	Proportion of Total 2018/19
General Medicine	1722	2003	2189	2084	1952	9.3%
Gastroenterology	1,689	1,803	1,827	1,882	1,485	8.4%
Orthopaedics	1,666	1,753	1,646	1,857	1,637	8.3%
Urology	1,330	1,432	1,577	1,609	1,583	7.2%
Respiratory Medicine	1,688	1,708	1,573	1,489	1,389	6.7%
General surgery	1,282	1,364	1,326	1,380	1,195	6.2%
Diagnostic GI Endoscopy	1,269	1,342	1,288	1,373	1,261	6.2%
Cardiology	1049	1237	1136	1173	1108	5.3%
Ophthalmology	1,036	1,077	1,004	1,036	896	4.6%
Obstetrics	908	900	967	913	898	4.1%
Other	7,653	8,064	7,909	7,506	7,410	33.7%
Total	**21,292**	**22,683**	**22,442**	**22,302**	**20,814**	**100.0%**

Source: CaSPA FlowInfo V20
Excludes: ED only, Unqualified Neonates, Renal Dialysis and Chemotherapy includes all hospitals

Table 19: Residents of Temora and surrounding areas demand for inpatient services by LGA 2015/16 to 2019/20

Patient Category	2015/16	2016/17	2017/18	2018/19	2019/20
01 - Acute	22,239	23,191	22,961	22,754	21,229
05 - Newborn care	608	574	641	648	664
02 - Rehabilitation	429	610	560	555	445
03 - Palliative	255	229	237	244	345
M - Mental Health		35	270	220	196
04 - Maintenance care	189	195	124	143	161
07 - Geriatric Eval./Management	75	62	84	74	92
Other	4	1	2	3	2
Total	**23,799**	**24,897**	**24,879**	**24,641**	**23,134**

Source: CaSPA FlowInfo V20
Excludes ED only, Unqualified Neonates, Renal Dialysis and Chemotherapy

Most services at Temora Hospital operate at RDL 2 - 3. Temora Hospital meets 4.6% of demand for the Temora and surrounding LGA residents. WWBH meets the majority of care (33.6%), and Wagga Wagga Collaborative Care meets a further 3.1% of separation demand. Private services meet another 26.2% separation demand. The remaining providers of small amounts of activity are shown in the table below.

Table 20: Treatment hospital for residents of Temora and surrounding areas demand for inpatient services by LGA 2015/16 to 2019/20

Treating Hospital	2015/16	2016/17	2017/18	2018/19	2019/20	% total 2019/20
Wagga Wagga(excl. Coll. Care)	6,084	6,829	7,569	8,045	7,772	33.6%
Private(excl DPCs) Hospitals	3,043	3,147	2,943	2,976	3,122	13.5%
Private Day Procedures	3,750	3,709	3,561	3,525	2,933	12.7%
Young	2,213	2,510	2,431	2,197	2,225	9.6%
Cootamundra	1,722	1,943	1,863	1,776	1,544	6.7%
Temora	1,196	1,092	1,172	1,110	1,067	4.6%
Wagga Wagga(Coll. Care)	585	623	619	666	719	3.1%
Gundagai	914	859	697	734	601	2.6%
Wyalong	613	702	579	627	558	2.4%
Mercy Young	320	306	291	288	309	1.3%
Other	3359	3177	3154	2697	2284	9.9%
Total	**23,799**	**24,897**	**24,879**	**24,641**	**23,134**	**100.0%**

Source: CaSPA FlowInfo V20, NSW MoH

The remaining demand for Temora and surrounding LGAs was sought elsewhere, the main being at WWBH and private services as identified above. It is appropriate that some services are provided at higher level facilities based on availability of specialty services or due to patient comorbidities which are more likely to have complications and require higher level support services. Use of private services is based on personal choice.

6.2.1 Maternity Services

Maternity services at Temora Hospital currently fluctuate between a level 2 to level 3 within the Centenary Hospital for Women and Children - Tiered Perinatal Network, dependent on workforce availability. The service provides low risk birthing and planned caesareans only.

A Neonatal level 2 service supports the obstetric service. This allows for immediate care for newborns greater than or equal to 37 weeks gestation where the mother is low risk. It includes the capacity for resuscitation and stabilisation of sick newborns and short-term respiratory support prior to transfer to higher level services. Short term care for such things as mild jaundice, hypoglycaemia requiring tube feeds and bilirubin measurement capacity is available.

The obstetric service is provided by two local GP Obstetricians (with a further GP currently pursuing post graduate qualifications in Obstetrics) midwives, and a perioperative team.

GP anaesthetist and perioperative nursing staff availability also impact on the service. The hospital has had issues with being on Critical Operations Standing Operating Procedure (COSOP's) for Obstetric emergencies due to a lack of medical and nursing staff. There is a well-established risk assessment process with clear pathways established. Local operating procedures are in place to ensure continuity of care for women as part of the COSOPS process when business continuity issues arise.

Anaesthetic services rely on a local GP Obstetrician who is also a GP Anaesthetist, and a visiting Anaesthetist from Young. MLHD have progressed workforce strategies to uplift and support maternity services at Temora as follows:

- Temora has three GP Obstetricians and a GP Obstetricians in training. They are also involved with the GP generalist program and have a Trainee GP anaesthetist coming to the area. They are very active in improving the Dr situation
- Theatres is well on its way to having the appropriate staffing to maintain an on-call service. Training is occurring and recruitment has been favourable.
- Inductions are occurring with the availability of OT staffing.
- Midwifery is currently training another student midwife and the situation with midwives is improving and not an issue now.

Maternity services consist of a six-bed wing with birthing suite, nursery and consultation room (for antenatal assessments). The wing is on the first floor, separated from the inpatient unit and operating theatre by public access corridor, elevator and stairwell.

The maternity area including the birthing suite and inpatient beds are staffed separately to the inpatient unit, irrespective of occupancy. If there are no patients, staff will assist on the inpatient unit. The separation of the Maternity inpatient beds, the general inpatient beds and the operating theatre results in disconnect between the staffing resources, particularly after hours.

Current Activity

Current acute maternity inpatient activity indicates that there was an average of 138 separations at Temora Hospital in the five years 2015/16 to 2019/20 with slight peaks in activity in 2015/16 and 2018/19.

Table 21: Temora Hospital Inpatient Activity 2015/16 to 2019/2020

Day Only Name	ESRG	2015/2016		2016/2017		2017/2018		2018/2019		2019/2020	
		Seps	Bed days	Seps	Bed days	Seps	Bed days	Seps	Bed days	Seps	Bed days
Overnight(s)	721 - Antenatal admission	23	28	21	24	24	25	23	32	12	13
	722 - Vaginal delivery	65	164	57	174	55	158	46	131	45	123
	723 - Caesarean delivery	18	71	18	80	11	43	13	48	8	32
	724 - Postnatal admission	23	52	19	65	33	88	50	122	43	81
Day only	721 - Antenatal admission	24	339	8	352	16	332	12	351	13	265
	722 - Vaginal delivery			1	1	2	2	3	3	2	2
	723 - Caesarean delivery							1			
	724 - Postnatal admission							2		1	
Grand Total		**153**		**124**		**141**		**150**		**124**	

Source: CaSPA FlowInfo V20
Includes: all LGAs
Excludes: chemotherapy, renal dialysis, ED only, HiTH only and unqualified neonates

N.B. The activity for 2018/19 has been used to demonstrate current service activity as the last reliable year of data as there were drops in inpatient and ED activity in 2019/20 because of the COVID-19 pandemic.

In 2018/19, there were 150 separations at Temora Hospital which accounted for a total of 686 beddays. Most of the activity was overnight with 88% of separations but only 48% of beddays. This equated to a total of 1.6 beds with 0.9 beds for overnight activity and 0.7 beds for day only activity. This activity would indicate that the occupancy rate for the inpatient maternity bed capacity in 2018/20 was 31% based on the current bed stock of 6 beds.

The average length of stay for overnight activity was 2.5 days.

Overnight activity accounted for most separations (88%) and beddays (48%).

The number of births has declined over the last five years from 83 births in 2015/16 to 55 births in 2019/20 or approximately 0.2 births a day. During the five years 2015/16 to 2019/20, planned caesarean sections made up around 20% of all births.

Table 22: Current Births at Temora Hospital 2015/16 to 2019/20

ESRG	2015/2016		2016/2017		2017/2018		2018/2019		2019/2020	
	Seps	Bed Days	Seps	Bed Days	Seps	Bed Days	Seps	Bed Days	Seps	Bed Days
722 - Vaginal delivery	65	164	58	175	57	160	49	134	47	125
723 - Caesarean delivery	18	71	18	80	11	43	14	49	8	32
Total	**83**	**235**	**76**	**255**	**68**	**203**	**63**	**183**	**55**	**157**
Beds		**0.5**		**0.5**		**0.4**		**0.4**		**0.3**
Occupancy		**8%**		**9%**		**7%**		**6%**		**5%**

Source: CaSPA FlowInfo V20

However, it is noted that the decrease in Maternity services over these five years could in part be attributed to the lack of appropriate obstetric and perioperative workforce capacity as well as pathology services, specifically cross matching, and blood products.

As a result of these impediments, the Maternity service at Temora Hospital has been limited to well women with no identified risks. Women who had any risk identified were referred to bigger centres e.g., WWBH and Griffith Hospital.

It is acknowledged that declining birth numbers is a safety and quality issue, which needs to be balanced with access for rural/regional women. MLHD risk assesses women to ensure the appropriate place of birthing

Currently there are other level 3 maternity services at Cootamundra (40-minute drive) and Young, which is a similar distance as WWBH, which could be utilised rather than transfer to WWBH for women suitable for level 3 birthing services when the service is on COSOPS, which should be occurring less frequently with workforce improvements. Where the woman is transferred is determined on a case-by-case basis depending on if the other sites have perioperative services.

The number of births at Temora during the previous five years 2010/11 to 2015/16 indicates that there were approximately 110 births per annum i.e., approximately 0.3

births a day. During these five years, caesarean sections made up approximately 33% of all births.

Table 30: Birthing Activity at Temora Hospital 2010/11 to 2015/16

ESRG	2010/11	2011/ 2012	2012/ 2013	2013/ 2014	2014/ 2015	2015/16
Caesarean delivery	36	18	28	25	29	18
Vaginal delivery	63	72	72	78	49	66
Temora Total	**99**	**90**	**100**	**103**	**78**	**84**

Source: CaSPA FlowInfo V20
Includes all LGAs

N.B. The activity for 2018/19 has been used to demonstrate current service activity as the last reliable year of data as there were drops in inpatient and ED activity in 2019/20 because of the COVID-19 pandemic.

In 2018/19, most of the obstetric demand at Temora Health Service was from Temora (52%) and the Bland Shire (36%). Very small numbers were from Junee, Hill Tops, Gundagai, and Lachlan.

Table 23: Temora Health Service Obstetric demand by LGA of Residence 2019/20

ESRG	Residence LGA 2016 Name	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020
721 - Antenatal admission	Bland (A)	30	12	>10	12	>10
	Temora (A)	23	19	19	15	11
	Other	>10	>10	>10	>10	>10
722 - Vaginal delivery	Bland (A)	23	17	18	18	19
	Temora (A)	30	33	29	23	24
	Other	11	>10	>10	>10	>10
723 - Caesarean delivery	Bland (A)	10	>10	>10	>10	>10
	Temora (A)	>10	12	>10	>10	>10
	Other	>10	>10	>10	>10	>10
724 - Postnatal admission	Bland (A)	>10	>10	10	18	22
	Temora (A)	15	13	20	30	18
	Other	>10	>10	>10	>10	>10
Grand Total		**170**	**128**	**135**	**149**	**133**

Source: FlowInfo V20, NSW MoH

6.2.2 *Surgical Services*

Description of Current Services

Surgical and procedural services at Temora Hospital currently operate at RDL 2-3. The service is provided by a local GP proceduralist (Obstetrician/Gynaecologist) and a local GP anaesthetist (scheduled lists only).

Current surgical services are almost exclusively obstetric (caesarean sections). A visiting general surgeon from WWBH has commenced low acuity day surgery procedures. General surgery lists are routinely scheduled every 4 weeks. Surgery lists include hernia repairs, skin surgery, haemorrhoids, varicose veins and carpal tunnel. Prior to the commencement of the outreach general surgeon service there were less than 20 procedures per year.

The ability to provide a viable sustainable service has been limited because of perioperative workforce availability. Perioperative nurses are drawn from the facility

nursing workforce, who also perform generalist ward, maternity, and emergency department duties when theatres are not in progress. It has been difficult for nursing staff to gain and maintain their skills with the limited amount of surgery being performed. MLHD is working to improve perioperative nurse workforce satisfaction by providing sufficient theatre activity to enable them to work exclusively within their specialty. There are perioperative nurses who reside within the Temora area who choose to work elsewhere within their specialty as they are not interested in working within ward or ED settings. An uplift in surgical activity will provide additional attraction and retention opportunities.

The MLHD Strategic Plan has an aspiration to excellence by maintaining an unyielding focus on quality and safety. There is one operating theatre which was refurbished in 2015 and 2016. Standards change over time in line with evidence-based quality and safety improvements.

An Audit conducted in 2019 identified that the operating theatre at Temora was compliant with current Australian Standards after the refurbishment in 2018. However two challenges were identified that impact on the optimal functioning of the current operating theatre. These included the size of the operating theatres – recently built operating theatres are much larger to accommodate the increasing use of technology and imaging modalities; as well there are issues with the location of the operating theatre which makes patient and staff flows challenging.

MLHD aspires to work towards a RDL 3 surgical service at Temora to meet MLHD's aim of maintaining an unyielding focus on quality and safety[27] and care as close to home as possible.

Current Activity

Current activity for the past five years indicates that there was a decline in episodes from 2015/16 to 2017/18 but an increase in the next two years. A visiting general surgeon from WWBH commenced low acuity day surgery procedures including hernia repairs, skin surgery, haemorrhoids, varicose veins and carpal tunnel.

During the five years, day surgery activity accounted for about 79% of all activity. On average, surgical, and procedural activity over the five years accounted for 0.12 to 0.21 beds.

Table 24: Current Surgical Activity at Temora Hospital 2015/16 to 2019/20

Value	Type Name	2015/2016	2016/2017	2017/2018	2018/2019	2019/2020
Total Separations	Day Only	6	3	2	23	41
	Overnight	4	5	3	6	15
Total Beddays	Day Only	6	3	2	23	41
	Overnight	10	29	7	65	17
Total Separations		10	8	5	29	56
Total Beddays		16	32	9	88	58
Total Beds		0.06	0.12	0.03	0.32	0.21

Source: CaSPA FlowInfo v20 - Includes all LGAs, Excludes Medical, Unqualified Neonates, Qualified Neonates, Renal Dialysis, Chemotherapy and Mental Health LGAs of Bland, Coolamon, Gundagai, Hilltops, Junee and Temora

[27] MLHD Strategic Plan 2016-2021

In the five years 2015/16 to 2019/10 demand for surgical services for residents in Temora and the surrounding areas remained constant with an annual average of 6,331 separations.

Table 25: Current Surgical Activity Demand for residents of Temora and surrounding LGAs 2015/16 to 2019/20

MPS	2015/16	2016/17	2017/18	2018/19	2019/20
Medical	14,199	15,098	15,246	14,632	13,858
Procedural	3,181	3,495	3,339	3,530	3,117
Surgical	6,419	6,304	6,294	6,479	6,159
Total	23,799	24,897	24,879	24,641	23,134

Source: CaSPA FlowInfo v20
Includes LGAs of Bland, Coolamon, Gundagai, Hilltops, Junee and Temora

6.3 SERVICE USE ELSEWHERE

Temora is a Peer Group Community Hospital with surgery. Most services operate at a role delineation level of one to three (Appendix 2). Over the five years 2015/16 to 2019/20, Temora LGA residents accessed 41% of services at Temora Health Service (separations) and 37% of bed day demand.

In the five years 2015/16 to 2019/10 demand for inpatient services for residents in Temora and surrounding areas remained constant with an annual average of 21,906 separations.

Table 26: Residents of Temora and surrounding areas demand for inpatient services by LGA 2015/16 to 2019/20

	2015/16		2016/17		2017/18		2018/19		2019/20	
Resident LGA	Seps	Bed Days	Seps	Bed Day	Seps	Bed Day	Seps	Bed Day	Seps	Bed Days
Bland (A)	2,575	9,488	2,691	9,198	2,563	8,075	2,633	8,171	2,299	7,386
Coolamon (A)	2,167	6,532	2,156	5,977	2,170	6,389	1,877	5,536	1,820	5,544
Gundagai (A)	5,582	16,694	6,121	18,817	5,941	17,641	6,190	18,297	5,500	17,102
Hilltops (A)	5,911	21,498	6,424	24,124	6,387	22,466	6,249	21,457	6,080	22,103
Junee (A)	2,282	7,732	2,407	6,891	2,564	8,144	2,606	8,184	2,494	7,717
Temora (A)	2,775	8,315	2,884	7,921	2,817	8,186	2,747	8,902	2,621	8,448
Total	**21,292**	**70,259**	**22,683**	**72,928**	**22,442**	**70,901**	**22,302**	**70,547**	**20,814**	**68,300**

Source: CaSPA FlowInfo v20
Includes all hospitals
Excludes ED only, unqualified neonates, renal dialysis, chemotherapy

In 2018/19, overnight activity made up most of the demand for inpatient services both in separations (53.7%) and beddays (84.7%). It's interesting to note that although 46.3% of demand separations were for day only this accounted for only 15.3% of beddays.

Table 27: Residents of Temora and surrounding areas demand for inpatient services by Day Only/Overnight split 2015/16 to 2019/20

Type	2015/2016		2016/2017		2017/2018		2018/2019		2019/2020		Proportion of Activity 2018/19 (%)	
	Separations	Bed Days	Separations	Bed Days	Separations	Bed Days	Separations	Bed Days	Separations	Bed Days	Separations	Bed Days
Day Only	11,909	11,909	12,412	12,412	12,140	12,140	12,045	12,045	11,002	11,002	46.3%	15.3%
Overnight	13,242	66,512	14,011	69,339	14,131	67,020	13,988	66,721	13,524	65,435	53.7%	84.7%
Total	25,151	78,421	26,423	81,751	26,271	79,160	26,033	78,766	24,526	76,437	100%	100%

Source: CaSPA FlowInfo v20
Includes all hospitals
Excludes ED only, unqualified neonates, renal dialysis, chemotherapy

In 2018/19, the top ten SRGs making up 66.3% of total demand activity were General Medicine (9.3%), Gastroenterology (8.4%), Orthopaedics (8.3%), Urology (7.2%), Respiratory Medicine (6.7%), Diagnostic GI Endoscopy and General Surgery (6.2%), Cardiology (5.3%), Ophthalmology (4.6%) and Obstetrics (4.1%).

Table 28: Residents of Temora and surrounding areas demand for inpatient services by SRG 2015/16 to 2019/20

SRG	2015/16	2016/17	2017/18	2018/19	2019/20	Proportion of Total 2018/19
General Medicine	1722	2003	2189	2084	1952	9.3%
Gastroenterology	1,689	1,803	1,827	1,882	1,485	8.4%
Orthopaedics	1,666	1,753	1,646	1,857	1,637	8.3%
Urology	1,330	1,432	1,577	1,609	1,583	7.2%
Respiratory Medicine	1,688	1,708	1,573	1,489	1,389	6.7%
General surgery	1,282	1,364	1,326	1,380	1,195	6.2%
Diagnostic GI Endoscopy	1,269	1,342	1,288	1,373	1,261	6.2%
Cardiology	1049	1237	1136	1173	1108	5.3%
Ophthalmology	1,036	1,077	1,004	1,036	896	4.6%
Obstetrics	908	900	967	913	898	4.1%
Other	7,653	8,064	7,909	7,506	7,410	33.7%
Total	**21,292**	**22,683**	**22,442**	**22,302**	**20,814**	**100.0%**

Most of the demand for services provided elsewhere was for acute services (92%).

Table 29: Residents of Temora and surrounding areas demand for inpatient services by Patient Category 2015/16 to 2019/20

Patient Category	2015/16	2016/17	2017/18	2018/19	2019/20
01 - Acute	22,239	23,191	22,961	22,754	21,229
05 - Newborn care	608	574	641	648	664
02 - Rehabilitation	429	610	560	555	445
03 - Palliative	255	229	237	244	345
M - Mental Health		35	270	220	196
04 - Maintenance care	189	195	124	143	161
07 - Geriatric Eval./Management	75	62	84	74	92
Other	4	1	2	3	2
Total	**23,799**	**24,897**	**24,879**	**24,641**	**23,134**

Source: CaSPA FlowInfo V20 - Excludes ED only, Unqualified Neonates, Renal Dialysis, and Chemotherapy. Includes all hospitals

Most services at Temora Hospital operate at RDL 2 - 3. Temora Hospital meets 4.6% of total demand for the Temora and surrounding LGA residents. WWBH meets the majority of care (33.6%), and Wagga Wagga Collaborative Care meets a further 3.1% of separation demand. Private services meet another 26.2% separation demand. It is appropriate that some services are provided at higher level facilities based on availability of specialty services or due to patient comorbidities which are more likely to have complications and require higher level support services. Use of private services is based on personal choice.

Table 30: Treatment hospital inpatient services for residents of Temora and surrounding areas for 2015/16 to 2019/20

Treating Hospital	2015/16	2016/17	2017/18	2018/19	2019/20	% total 2019/20
Wagga Wagga(excl. Coll. Care)	6,084	6,829	7,569	8,045	7,772	33.6%
Private(excl DPCs) Hospitals	3,043	3,147	2,943	2,976	3,122	13.5%
Private Day Procedures	3,750	3,709	3,561	3,525	2,933	12.7%
Young	2,213	2,510	2,431	2,197	2,225	9.6%
Cootamundra	1,722	1,943	1,863	1,776	1,544	6.7%
Temora	1,196	1,092	1,172	1,110	1,067	4.6%
Wagga Wagga(Coll. Care)	585	623	619	666	719	3.1%
Gundagai	914	859	697	734	601	2.6%
Wyalong	613	702	579	627	558	2.4%
Mercy Young	320	306	291	288	309	1.3%
Other	3359	3177	3154	2697	2284	9.9%
Total	**23,799**	**24,897**	**24,879**	**24,641**	**23,134**	**100.0%**

Source: FlowInfo V20, NSW MoH

Table 31: Treatment hospital bed day demand for inpatient services for residents of Temora for 2015/16 to 2019/20

Hospital Name	2015/ 2016	2016/ 2017	2017/ 2018	2018/ 2019	2019/ 2020	% 2018/ 19
Temora	3036	2545	2608	2994	2911	32.8
Wagga Wagga (excl. Coll. Care)	2319	2035	2710	3179	2683	34.8
Private (excl DPCs) Hospitals	1409	1548	1361	1257	1431	13.8
Private Day Procedures	505	539	514	511	377	5.6
Canberra	125	171	232	176	200	1.9
Wagga Wagga (Coll. Care)	276	223	222	140	160	1.5
St. Vincent's - Public	222	109	175	191	151	2.1
Cootamundra	36	45	69	46	51	0.5
Young	40	49	34	13	18	0.1
Mercy Young	14	23	27	97		1.1
Other MLHD hospitals	67	50	32	145	51	1.6
Other NSW hospitals	256	573	333	292	514	3.2
Other State and Territory hospitals	52	33	43	88	93	1.0
Grand Total	**8354**	**7941**	**8360**	**9129**	**8633**	**100.0**

Source: FlowInfo V20, NSW MoH – excludes ED only, chemotherapy, renal dialysis and unqualified neonates

Total inpatient bed demand by Temora residents at any site equates to 31 beds at 85% occupancy based on 2018/19 activity. Demand at Temora hospital by Temora residents equates to 10 beds. This does not include the demand at Temora by residents from other LGA's.
The remaining demand by Temora residents are sought elsewhere (21 beds) as shown above. These are generally for higher level services unable to be provided in smaller settings due to comorbidities of the patient or specialty of the service required. Patients may also be transferred for diagnostics such as to WWBH and remain there. Additional diagnostic modalities may impact on the number requiring transfer in the first instance.

Choice of service provider by the patient is also a strong factor. Private Service use equates to six beds. Renal dialysis and chemotherapy services are almost exclusively sought by Temora residents at WWBH and private services/Wagga Wagga Collaborative Care, respectively.

7. EMERGENCY AND INPATIENT SERVICES - PROPOSED

7.1 EMERGENCY SERVICES FUTURE MODELS OF CARE

Temora Health Service will provide a RDL 3 ED service and MHECS. Virtual Care will be an integral component of the model for bedside critical care advice and support through the Patient Flow Unit. There will be an enhancement of Virtual Care modalities to provide additional clinical support and advice.

A RDL 3 service has the capability to manage a full range of emergency presentations, including some complex emergency cases and paediatric presentations. The service provides primary emergency care, including short term mechanical ventilation, pending transfer to definitive care. It provides a 24-hour clinical triage service in accordance with Australian Triage Scale.

It can respond to local major incidents, with a formal role in disaster response planning[28].

Several strategies can be implemented to reduce and/or better manage patients attending ED. These are described below.

ED Avoidance

ED avoidance strategies are aimed at reducing presentations to ED or redirecting patients away from the acute area if they do present to the hospital. Examples include:

- availability of after-hours GP clinics or alternative Nurse Practitioner clinics
- access to specialist, nurse or allied health led outpatient clinics
- education sessions or group sessions e.g., Diabetes Education Sessions; Antenatal Classes
- direct referrals to specialist teams for chronic and complex patients either by phone or Virtual Care
- care coordination/management, particularly for chronic disease management
- GP liaison
- prevention and health promotion programs

Outpatient clinic/unplanned return presentations

Currently outpatient clinic type presentations who present with less serious illnesses and injuries as well as unplanned return visits for the same condition account for nearly a quarter of all presentations (22%). These are patients who can be potentially being discharged within < 2 hours. New models of care will ensure timely management and discharge of these patients.

Alternative models will be implemented at Temora Health Service to better manage these patients, particularly on weekends. Identified triage flows and consultation spaces will be provided within the new ED for this function. These will be staffed by GPs, a Nurse Practitioner, or very experienced RNs. This will provide increased service capacity, particularly on weekends.

[28] NSW Health Guide to the Role Delineation of Clinical Services – Section Two – Clinical Services: Part A Emergency Medicine

As well, non-Admitted Services outpatient services are being proposed that will redirect activity from ED both for the initial consultation and follow-up consultations. These will include outpatient clinics, community health/HiTH and MH&D&A services. Services provided by these services will include but not limited to:

- Ante natal and post-natal
- post-acute services
- adult HiTH
- Allied Health
- fracture clinics
- wound care
- child and family
- mental health
- drug and alcohol

Linkages with other service providers will be enhanced to reduce the number of ED presentations.

Mental Health and Drug & Alcohol and Cognitively Impaired

Mental Health patients presenting with a broad range of mental health problems and those with cognitive impairment who present to the ED will be managed by suitably trained staff to assist in de-escalating the situation in response to individual client's needs.

There will need to be the ability to manage patients overnight when transfers to higher level services are delayed. Because ED is not separately staffed after hours, a suitable space on the inpatient ward is also required.

Virtual Care will be used for patients presenting with acute mental health and cognitively impaired issues, linking patients and staff to specialist mental health emergency staff for patient assessments and recommendations for management and treatment.

The continuing rollout of the Collaborative Care Strategy will enhance client's ability to access personalised mental health services by allowing them to be a partner in their own care.

While the majority of clients on the Opioid Treatment Program (OTP) obtain their medications through private pharmacies, discrete facilities for the administration of these medications to the remaining client group presenting to the ED will need to be provided to respect the privacy and avoid the stigmatisation of these clients.

Use of Virtual Care modalities

The increased use of Virtual Care will allow for better and quicker management of patients presenting to ED as well as accessing appropriate levels of specialised services if required.

Facilities for undertaking Virtual Care will be located throughout ED. This will include fixed cameras in the Resuscitation area and additional supporting technology such

as, but not limited to such things as remote monitoring etc. As well mobile technology will allow for videoconferencing and future technological applications to be provided at all bedsides. These can be used to do consultations with specialist services including retrieval services, Mental Health services and others as required.

It is proposed that the use of robotic cameras for ED will be investigated. These are easy to use, controlled centrally and increasingly 'hands free' which allows local staff and staff at the other sites to have constant, 'real time' communications to best manage patient care. The use of health robotics helps improve patient care and outcomes while increasing operational efficiency.

Consultation space for outpatient Virtual Care to enable community members to link to MLHD or metropolitan services will be provided in the Wellness Centre. This improves access where technological literacy is poor and/or access to technology in the home is absent or limited by band width/cost.

7.2 Emergency Services Projected activity

Base Case

Assumes models of care and patient flows will remain largely unchanged to the existing service activity profile.

The base case indicates that ED activity will remain relatively constant within the proposed population projections.

Table 40: Projected ED activity at Temora Hospital 2015/16 to 2036

Triage Category	2015	2021	2026	2031	2036
1	10	13	12	12	12
2	115	161	198	200	201
3	490	490	495	499	502
4	1,279	1,232	1,248	1,257	1,266
5	1,386	1,334	1,347	1,357	1,364
N\A	1	1		1	1
Total	3,281	3,231	3,300	3,325	3,345

Source CaSPA EDAA

This activity equates to a requirement for 2.3 treatment spaces. Treatment spaces include resuscitation and treatment bays but do not include other standard components of ED such as plaster rooms, triage spaces and consultation spaces.

Consideration of patient cohorts needs to occur in terms of meeting the requirements for child safe treatment and waiting spaces (visual and auditory exposure inclusive) and for sexual assault, domestic violence and child protection presentations.

Facility requirements

The ED needs to be reconfigured to optimise patient and staff flows and address line of sight issues. Additional spaces including a consultation room and a low stimulus room suitable for people who present with an altered cognitive state to feel safe

while awaiting review need to be included. A low stimulation environment specifically designed to deescalate aggravation will be required within the ED in a quieter zone away from resuscitation and acute bay, while providing good access to and oversight by staff.

This room can be multifunctional and used for any patients requiring a quieter space away from resuscitation/treatment bay area who do not require a treatment bay for their immediate clinical care.

It is proposed that in addition to standard components (including triage, plastering capacity etc) there will need to be:

- 1X resuscitation bay
- 2 X acute treatment bays including 1 X enclosed and child safe
- 1 isolation room
- 1 low stimulus room to manage people with altered cognitive state and for Mental health emergency consultancy service MHECS consultations
- 1 X treatment room (for Nurse Practitioner/GP clinic) (attached to ED or could be in Wellness Centre dependent on workforce model)

One space will be designed specifically to be child friendly to provide appropriate accommodation for children presenting to the ED.

Critical Care Virtual Care capability will be available in the resuscitation bay for linking with MLHD Critical Care Advisory Service and medical retrieval services. Mobile virtual care technology will be required to be used flexibly including in the low stimulus space.

In general, technology uplift is required to support virtual care needs including but not limited to availability management as part of access to specialist staff for mental health emergency services, and unified communications services (video conferencing and bed-side monitoring of vitals and visual access back to central location such as staff desk/ WWBH Critical Care Service).

7.4 INPATIENT SERVICES FUTURE MODELS OF CARE

There will be an increase in short stay, ambulatory, outpatient and community-based care. The increased utilisation of short stay models of care in a range of clinical services from aged care, surgery and medical will result in shorter but more intense interactions between patients, families and health care providers. This will lead to a greater turnover of patients through the inpatient beds.

The inpatient services will continue to provide overnight and extended day only accommodation for the diagnosis, care, and treatment of acute inpatients by multidisciplinary teams. Whilst facilitating the delivery of services to patients, the inpatient areas will also provide facilities to support the needs of families, carers and staff.

The acute inpatient beds will accommodate several different clinical services. These being:

- Medical (including rehabilitation)
- Surgical
- Close Observation
- Maternity
- Neonatal

While there is no plan to move to an admitted paediatric service (level 3), child safe spaces on the ward (and in the ED) are required to enable the facility to meet a level 2 paediatric service including the ability to provide observation and stabilisation pending possible transfer; (may be up to 48 hours following paediatrician consultation). With a review of the NSW Paediatric Capability Framework underway, there may be a further push to increase access for common paediatric admissions closer to home through networked arrangements.

7.4.1 ACUTE MEDICAL SERVICES

Medical

Medical services at Temora Hospital will include a broad range of medical services relating to general acute, geriatric medicine and chronic conditions. These services will focus on the management of acute and chronic disease.

The key services will comprise general medicine, gastroenterology, respiratory medicine, and cardiology.

Inpatient services will have access to diagnostic pathology and imaging to facilitate rapid diagnoses and commencement of treatment.

Surgical

There will be uplift in surgical and procedural services provided at Temora Hospital. The development of a sustainable perioperative service operating at RDL 3 will enable clinically appropriate surgical services to be provided locally, supporting the delivery of new technologies and contemporary models of care and achieve flow reversals to enable patients to access services closer to home.

Most procedures will be planned and in scheduled lists operating five days a week. Most patients will be day only with a small number of patients requiring overnight stays.

Close Observation

Close Observation RDL 3 capacity is required to support a RDL 3 perioperative service. This will include a dedicated two bed close observation unit with continuous monitoring and telemetry capacity to provide for more intense management of patients who require a higher degree of monitoring and observation than standard based care as per NSW Guide for Role Delineation of Clinical Services and the NSW Agency for Clinical Innovation Close Observation Units – Key Principles. https://aci.health.nsw.gov.au/__data/assets/pdf_file/0007/430837/Close-Observation-Units-Key-Principles.pdf

The service will be networked with the WWBH level 5 intensive care services and Critical Care Advisory Service, who will provide clinical support, and clinical backup for patients through digital health technologies.

7.4.2 MATERNITY

The Maternity Service at Temora Hospital will aspire to operate as a fully functional level 3 service supported by a Neonatal level 2 service. The maternity model at Temora Health Service will continue to be part of the MLHD tiered maternity network, with escalation of care for women presenting outside the service capability to either Wagga or Centenary Hospital for Women and Children - Tiered Perinatal Network. The Manager Midwifery, Clinical Midwifery Consultant and Midwifery Educator are key support roles for the Temora service.

Models of care will support the philosophy that pregnancy, birth, and the postnatal period are normal physiological processes and facilitate the principles outlined within the NSW Health Policy Directive 2010_045 Maternity – Towards Normal Birth in NSW. It should be recognised that during the antenatal, perinatal, and postnatal stages, a woman can move between the various models of care depending on her and/or her baby's clinical condition.

Maternal services will encompass outpatient antenatal care, inpatient perinatal care, inpatient, and outpatient postnatal care for women with normal pregnancies or those with variance from normal but within categories A and B of the Australian College of Midwifery National Guidelines for Consultation and Referral and Neonatal Services.

Level 3 capabilities for maternity services include inductions and planned caesareans and the ability to undertake emergency caesareans if required. A level 3 maternity service can provide care to women with moderate risk factors, by provision of collaborative care, including GP obstetricians.

The current shared care arrangement with the local GP obstetricians will continue where one RM and one GP provide care for the woman during her pregnancy and birth as well as postnatal care. This combined model will provide residents with optimal choice as to their birthing options.

A level 2 Neonatal service will provide for return transfers of preterm and convalescing infants, more than >35 weeks corrected age requiring minimal ongoing care. It will also provide short term care for simple neonatal complications e.g., jaundice only requiring single light therapy as well as short term tube feeding[29].

Virtual Care will play a major role in the uplift of the services with linkages to higher level services for support and case management. Virtual Care antenatal options should be incorporated to reduce travel burden where it is safe to do so. Intrapartum virtual care support options and technologies such as centralised foetal heart rate monitoring and cameras like critical care advisory service should also be incorporated as models of care progress.

[29] NSW Health Guide to the Role Delineation of Clinical Services Section Two – Clinical Services: Part D: Child and Family Health Services. P. 111

The Maternity service will operate as a publicly funded midwifery service. The service will provide ante natal, intrapartum, and post-natal care. Support from the GP obstetricians will be integral if a complexity if identified during the pregnancy or the birth e.g., meconium-stained liquor or labour dystocia. Women who are identified as requiring higher level of care will be referred to a GP Obstetrician or transferred to a higher service capability site for ongoing care.

This model will require two Registered Midwives (RM) to be rostered on every shift. This would allow one RM to support the woman during the labour and birth and the other midwife to be available to provide care to the neonate following birth. Uplift in skills including management of 1st and 2nd degree perineal tears will be required for the midwives.

There will also be a need to consider the skills and upskilling of GP proceduralists in management of 3rd degree perineal tears which are more likely with vacuum/forceps births.

Access to a fully functioning operating theatre is integral to the management of risks associated with birthing including emergency caesareans. As well, a functioning operating theatre is required to support women undergoing planned inductions in case the patient requires an emergency caesarean section. Access to a RDL 3 Pathology service is also an integral component in the provision of level 3 maternity services.

Currently education and training of midwives occurs at Temora Health Service. Post Graduate midwives are employed for 12 months during their training. Midwives undertaking Bachelor of Midwifery training are not employed by the district but come into the hospitals for clinical experience. Students go to WWBH for Special Care Nursery and complex maternity experience.

Assistants in Midwifery are students who are currently undertaking their Bachelor of Nursing training as well as post graduate students are employed by the district and work in the maternity units. The bulk of new recruits are direct entry midwives who have completed their Bachelor of Midwifery.

7.4.3 Sub-Acute services

Subacute services are divided into several different clinical areas. These include:

- Rehabilitation
- Palliative Care
- Geriatrics

Rehabilitation

Rehabilitation is the process of assisting individuals achieves the highest level of function, independence, and quality of life possible. Rehabilitation does not reverse or undo the damage caused by disease or trauma, but rather helps restore the individual to optimal health, functioning, and well-being.

A RD 3 inpatient and ambulatory Rehabilitation Service will be introduced at Temora Hospital. It will be a hub for both inpatient and community-based services including outpatient and outreach services. This will include rehabilitation services for patients requiring reconditioning with a range of medical conditions including stroke as well as pre-rehabilitation and post rehabilitation for patients undergoing surgical procedures.

Pre-rehabilitation and post-rehabilitation services will be a component of the service. The goal of pre-operative rehabilitation is to help patients undergoing planned surgical procedures e.g., joint replacements, tendon and soft tissue repairs and fracture management are as well-conditioned as possible prior to surgery to enhance post-operative recovery. Post-operative rehabilitation is important in achieving the optimum outcome from surgery and in minimising the risk of complications.

The service will provide services to residents of the Temora LGA. The service will also accommodate patients currently accessing services at WWBH and other MLHD facilities and beyond.

The service will be provided on site and with visiting staff including nursing, allied health, and rehabilitation specialists. Virtual Care will play a major role in the implementation of the service and will provide ongoing support and case management.

Appropriate facilities will be provided at Temora Health Service to support the service. This will include ADL facilities including kitchen/laundry, bathroom and dining/recreation room in the inpatient unit. A gym, a group room and other support facilities will be located in the Wellness Centre. This will optimise the utilisation of these spaces by both inpatients and outpatients. They can also be used for community activities.

Pulmonary and Cardiac rehabilitation services will support the large number of residents with cardiac and pulmonary conditions through a potential Collaborative Commissioning model including building a Chronic Heart Failure and Chronic Obstructive Pulmonary Disease pathway with the Murrumbidgee Primary Health Network.

<u>Palliative Care</u>

Currently services are provided through specialist teams with three nurses providing outreach services in Temora. It operates a collaborative model with community nursing to provide consultative services. At present there is a shortage of community nurses which makes the provision of services in the community difficult.

There is an Aboriginal Health worker included in the team as well as a Bereavement support worker.

Ambulance paramedics have extended scope of practice and can administer a range of medications for managing symptoms to assist patients remaining in their homes.

- Opportunities for future service provision include:
- Progressing to on call medical model

- Two Sydney specialists to be located at WWBH
- Training up staff in hospitals
- Increase on call model at Wagga, Deniliquin and Griffith
- Face to face after hours
- Syringe driver management – set for 24, 48 or 72 hours
- Virtual Care modalities will be a major enabler
- New workforce models to ensure appropriate support

Moving forward into the future there is a need to have conversations with the community as to what is perceived to be a 'normal death'. Educating the community to the notion that not all deaths must be in a hospital setting will allow patients to have a choice as to where they die.

However, there will need to be discrete facilities to accommodate palliative care patients who do wish to die in the hospital setting or who are admitted for symptom control. This needs to include a collaborative working space to optimise patient care. Support for multiple faiths and family providing bedside care will be part of the inpatient model.

Geriatrics

There is a need to explore models of care to provide geriatric specific support services to both inpatients and patients in the community. Geriatric models will need to provide services with a combination of inpatient services for managing the acute care needs of the older population whilst also optimising the shift of care to off-site with most services provided in the community. The use of Virtual Care will be used to support older patients in the hospital as well as in the community setting including in patient's homes.

Enhancement of outreach services provided by Clinical Nurse Consultants and other appropriate support services will allow patients to remain in their homes. This will be assisted with the introduction of a RDL 3 rehabilitation service.

Currently, there are 79 Residential Aged Care Facility beds in Temora provided in the Whiddon Aged Care facility next door to the current hospital. Ageing in place puts pressure on the hospital with many clients preferring to go into care if beds were available. Currently there are at least 10 people on the waiting list for placement in Whiddon Aged Care.

The provision of appropriate facilities in the inpatient setting for patients with difficult behaviours including wandering and confusion needs to be considered.

Infection Control

The need to accommodate patients with airborne pathogens has been at the forefront with the COVID pandemic over the last few years. For patients requiring inpatient care, appropriate facilities including single rooms and good air conditioning are essential to reduce the spread. Staff adequately trained in infection control procedures is also essential.

The increased use of single rooms in new facilities will assist in reducing the spread of airborne contaminants.

7.5 INPATIENT PROJECTED ACTIVITY

7.5.1 ACUTE MEDICAL/SURGICAL INPATIENT SERVICES

Base Case acute medical

Assumes models of care and patient flows will remain largely unchanged to the existing service activity profile.

The base case indicates that inpatient activity shows a slight increase in activity from 1,105 episodes in 2015/16 to 1,126 episodes in 2031. This would reflect an increase in beds required from 12.5 beds in 2015 to 13.7 beds in 2031. Average length of stay is proposed to increase slightly from 3.1 days in 2015/16 to 3.3 days in 2031/32.

Table 32: Base Case Temora Hospital Projected Acute Inpatient Activity 2015 to 2031

	Episodes					Bed Days					Beds				
Acute Medical															
Stay Type	**2015**	**2021**	**2026**	**2031**	**2036**	**2015**	**2021**	**2026**	**2031**	**2036**	**2015**	**2021**	**2026**	**2031**	**2036**
Day Only	158	173	173	191	185	158	173	173	191	185	0.4	0.4	0.4	0.5	0.5
Overnight	701	712	713	754	797	2571	3,134	3,024	3,125	3,188	9.4	11.4	11.0	11.4	11.6
Total	**859**	**885**	**886**	**945**	**982**	**2,729**	**3,307**	**3,197**	**3,316**	**3,373**	**9.8**	**11.9**	**11.5**	**11.9**	**12.1**
Acute Surgical/Procedural															
Stay Type	**2015**	**2021**	**2026**	**2031**	**2036**	**2015**	**2021**	**2026**	**2031**	**2036**	**2015**	**2021**	**2026**	**2031**	**2036**
Day Only	5	3	3	4	4	5	3	3	4	4	0.0	0.0	0.0	0.0	0.0
Overnight	19	15	15	13	17	130	60	54	52	62	0.5	0.2	0.2	0.2	0.2
Total	**24**	**18**	**18**	**17**	**21**	**135**	**63**	**57**	**56**	**66**	**0.5**	**0.2**	**0.2**	**0.2**	**0.2**
Maternity															
Stay Type	**2015**	**2021**	**2026**	**2031**	**2036**	**2015**	**2021**	**2026**	**2031**	**2036**	**2015**	**2021**	**2026**	**2031**	**2036**
Day Only	17	15	14	11	15	17	15	14	11	15	0.0	0.0	0.0	0.0	0.0
Overnight	205	159	159	153	133	592	484	464	428	368	2.2	1.8	1.7	1.6	1.3
Total	**222**	**174**	**173**	**164**	**148**	**609**	**499**	**478**	**439**	**383**	**2.2**	**1.8**	**1.7**	**1.6**	**1.4**
Total Inpatient															
Stay Type	**2015**	**2021**	**2026**	**2031**	**2036**	**2015**	**2021**	**2026**	**2031**	**2036**	**2015**	**2021**	**2026**	**2031**	**2036**
Day Only	180	191	190	206	204	180	191	190	206	204	0.4	0.5	0.5	0.5	0.5
Overnight	925	886	887	920	947	3,293	3,678	3,542	3,605	3,618	12	13.4	12.9	13.2	13.2
Total	**1,105**	**1,077**	**1,077**	**1,126**	**1,151**	**3,473**	**3,869**	**3,732**	**3,811**	**3,822**	**12.5**	**13.9**	**13.4**	**13.7**	**13.7**

Source: HealthAPP base case
Excludes: Chemotherapy, Renal Dialysis, Unqualified Neonates

Scenario Case acute medical/surgical inpatient

An exercise has been undertaken under this scenario to identify the projected demand for acute inpatient services at Temora Hospital to 2031 and beyond. This reflects the uplift of services and the reversal of activity from other hospitals.

With the uplift of both the Surgical and Maternity services to a full L3, it would be predicted that a greater number of local residents will access Temora Hospital for treatment. As well it will be important to build acute inpatient services at Temora Hospital to accommodate residents from neighbouring regions. This could include West Wyalong, Junee and Coolamon.

It is predicted that there will be a total of 31% increase in the overall acute day only and overnight activity at Temora Hospital to 2031. The greatest increase will be in surgical activity as a result of a fully functioning Perioperative Service (900%) followed by Maternity (25%) and Acute Medical (18%).

Table 33: Scenario Case Temora Hospital Projected Acute Inpatient Activity 2026 to 2031

Type	Base Case		Scenario		Variance (%)
	2026	2031	2026	2031	
Acute Medical	11.5	11.9	13.0	14.0	18%
Acute Surgical	0.2	0.2	1.0	2.0	900%
Maternity	1.7	1.6	1.9	2.0	25%
TOTAL BEDS	**13.4**	**13.7**	**15.9**	**18.0**	**31%**

Source: HealthAPP base case
Excludes: Chemotherapy, Renal Dialysis, Unqualified Neonates

This reflects an overall increase of 4 beds for acute services from the base case.

N.B. the increased number of inpatient surgical beds will be for accommodating extended day only surgical patients as well as surgical patients who don't undergo a surgical procedure.

7.5.2 MATERNITY

Base Case maternity

Assumes models of care and patient flows will remain largely unchanged to the existing service activity profile.

The base case indicates that obstetric activity will decrease from 222 episodes in 2015/16 to 164 episodes in 2031. This would reflect a decrease in beds required from 2.2 beds in 2015 to 1.6 beds in 2031. Average length of stay is proposed to be 2.7days.

Table 34: Base Case Projected Obstetric Activity at Temora Hospital 2015/16 to 2036

	Episodes					Bed Days					Beds				
Stay Type	2015	2021	2026	2031	2036	2015	2021	2026	2031	2036	2015	2021	2026	2031	2036
Day Only	17	15	14	11	15	17	15	14	11	15	0.0	0.0	0.0	0.0	0.0
Overnight	205	159	159	153	133	592	484	464	428	368	2.2	1.8	1.7	1.6	1.3
Total	**222**	**174**	**173**	**164**	**148**	**609**	**499**	**478**	**439**	**383**	**2.2**	**1.8**	**1.7**	**1.6**	**1.4**

Source: CaSPA HealthAPP

N.B. there is a difference between the actual activity for 2019 (124 separations) and what was projected for 2020 (174 separations). This would indicate that obstetric activity at Temora Health Service was operating well under what was predicted (50 less separations). However, it must be noted that the projection tool used the base year of 2015 which was the old activity baseline: 2015 has been identified as one of the years demonstrating a decrease in Maternity services in part due to the lack of appropriate obstetric and perioperative workforce capacity and Pathology services, specifically cross matching, and blood products.

Scenario Case maternity

With the uplift of the service to a full level 3 it would be predicted that a greater number of residents will remain at Temora Hospital to birth. As well it will be important to build up maternity services at Temora Hospital to accommodate women from neighbouring regions. This could include West Wyalong, Junee and Coolamon.

An exercise has been undertaken under this scenario to identify the projected demand for maternity services at Temora Hospital to 2031 and beyond. This includes an additional 50% births extrapolated from 2026 to 2036. This reflects the uplift of services and the reversal of activity from other hospitals. As well it reflects potential population shifts to regional and rural centres which could continue post the COVID pandemic. This is anticipated as housing affordability in metropolitan areas decreases, particularly for young families.

This would indicate that the number of births at Temora Hospital could increase from 176 births in 2021 to 205 births by 2031.

Table 43: Scenario Case Projected Obstetric Activity at Temora Hospital 2015 to 2036 by ESRG

ESRG	2015	2021	2026	2031	2036
Caesaean delivery	18	53	57	68	74
Vaginal Delivery	66	123	132	137	152
Temora Total	**84**	**176**	**189**	**205**	**226**

Source: HealthAPP base case

Currently planned caesarean births make up 20% of all births. However, there was a higher level of caesarean births in the years 2010/11 to 2015/16 (33%). If this higher caesarean rate was to continue with the higher level of births, it would be anticipated that there would be an average of 54 caesarean births per year.

7.5.3 SUB-ACUTE INPATIENT SERVICES

Base Case sub-acute

Assumes models of care and patient flows will remain largely unchanged to the existing service activity profile.

The base case indicates that inpatient activity shows a slight increase in activity from 71 episodes in 2015/16 to 111 episodes in 2031. This would reflect an increase in beds required from 2.7 beds in 2015 to 2.8 beds in 2031 and 2036.

Table 35: Base Case Temora Hospital Projected Sub Acute Inpatient Activity 2015 to 2036

	Episodes					Bed Days					Beds				
SRGName	2015	2021	2026	2031	2036	2015	2021	2026	2031	2036	2015	2021	2026	2031	2036
84 - Rehabilitation		3	6	4	5		50	132	81	89	-	0.2	0.4	0.2	0.3
86 - Palliative Care	30	38	39	51	48	355	266	272	352	326	1.1	0.8	0.8	1.1	1.0
87 - Maintenance	41	50	54	56	60	534	539	512	490	492	1.6	1.6	1.6	1.5	1.5
Total	**71**	**91**	**99**	**111**	**113**	**889**	**855**	**916**	**923**	**907**	**2.7**	**2.6**	**2.8**	**2.8**	**2.8**

Source: HealthAPP base case
Includes Sub Acute SRGs only

Scenario Case sub-acute

An exercise has been undertaken under this scenario to identify the projected demand for subacute inpatient services at Temora Hospital to 2031 and beyond. This reflects the upgrading of the RDL 3 rehabilitation service on site to include inpatient capacity and the reversal of activity from other hospitals.

Capacity will be required to accommodate the inpatient component of the RDL 3 rehabilitation service proposed to be introduced at Temora Hospital.

It is predicted that there will be a total of 4.3% increase in the overall sub-acute day only and overnight activity at Temora Hospital to 2031. The greatest increase will be in Rehabilitation (9.4%) followed by Palliative Care (4.6%) and Maintenance (3.2%).

Table 36: Scenario Temora Hospital Projected Sub Acute Inpatient Activity 2015 to 2036

SRG	2015	2021	2026	2031	2036	Variance
Separations						(%)
Rehabilitation	4	5	9	10	10	9.4%
Palliative Care	50	63	68	87	86	4.6%
Maintenance	37	46	53	56	62	3.2%
TOTAL	**91**	**114**	**130**	**153**	**158**	**4.3%**
Beddays						
Rehabilitation	53	66	119	132	132	9.4%
Palliative Care	370	466	503	644	636	4.6%
Maintenance	833	1,035	1,193	1,260	1,395	3.2%
TOTAL	**1,255**	**1,567**	**1,815**	**2,036**	**2,163**	**3.9%**
Beds						
Rehabilitation	0.6	0.8	1.4	1.9	1.9	13.5%
Palliative Care	0.8	1.0	1.0	1.3	1.3	4.6%
Maintenance	1.7	2.1	2.5	2.6	2.8	3.2%
TOTAL	**3.1**	**3.8**	**4.8**	**5.8**	**6.0**	**5.6%**

Source: HealthAPP base case

This reflects an overall increase of 3 beds from the base case for subacute services.

N.B. the large increase in Rehabilitation services is as a result of the commencement of a RDL3 Rehabilitation Service at the hospital.

Facility Requirements

The above exercises would indicate that the total number of inpatient beds required at Temora Health Service in 2031 ranges from 16.5 beds for the base case to 24 beds for the scenario. This is a reduction of four beds from current built capacity of 28 beds.

Table 6: Temora Hospital Projected Inpatient Infrastructure Requirements 2026 to 2031

Type	Base Case		Scenario	
	2026	2031	2026	2031
Acute Medical	11.5	11.9	12.5	14.0
Acute Surgical	0.2	0.2	1.0	2.0
Maternity	1.7	1.6	1.9	2.0
Acute Beds	**13.4**	**13.7**	**15.4**	**18.0**
Rehabilitation	0.4	0.2	2.0	2.6
Palliative Care	0.8	1.1	0.9	1.2
Maintence	1.6	1.5	1.7	2.2
Sub Acute Beds	**2.8**	**2.8**	**4.6**	**6.0**
TOTAL BEDS	**16.2**	**16.5**	**20.0**	**24.0**

Source: HealthAPP base case

As the scenario case best reflects the new and evolving services and models of care to be provided at the hospital by 2031, it would be recommended that 24 beds be built in the new facility to accommodate the projected service activity.

7.6 Perioperative Services Future Model of Care

MLHD are committed to the continuing provision of surgery and procedural services in Temora due to its ability to enhance existing surgical and procedural activity within the Cluster and beyond.

A consolidation of services and workforce across the district would enhance its ability to achieve the principles of equity, access, sustainability and ownership.

There will be uplift in surgical and procedural services provided at Temora Hospital. The development of a sustainable perioperative service at RDL 3 will enable clinically appropriate surgical services to be provided locally, supporting the delivery of new technologies and contemporary models of care and achieve flow reversals to enable patients to access services closer to home.

A range of services will be provided within the perioperative service and can include screening and prevention, comprehensive preoperative assessment, intra-operative, postoperative recovery, discharge planning and community follow-up.

There is a need to increase the utilisation of perioperative services to ensure the service is viable and sustainable. Planned procedures with scheduled lists will be provided by local and visiting surgeons. There will be an increase in access to additional specialties as outlined and to compliment GP proceduralist and GP anaesthetist availability into the future.

The development of a comprehensive perioperative service and additional anaesthetic enabled procedure room will assist in supporting, teaching and attracting and retaining appropriately skilled and qualified nursing and support staff as well as visiting surgeons and anaesthetists. Importantly it will provide support and teaching opportunities for local GP VMO proceduralists and anaesthetists to reduce the need to travel to Wagga Wagga for education/training and skills maintenance.

Most procedures will be planned and in scheduled lists operating five days a week.

The range of surgical and procedural procedures provided will be enhanced to include:

- low level orthopaedics
- ophthalmology
- endoscopy
- laparoscopes
- urology and
- gynaecology.

Planned caesarean sections will continue to be performed as well as emergency caesareans in line with GL2022_002 Maternity and Neonatal Service Capability Guideline.
https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2022_002.pdf

It is proposed that Temora becomes one of a number of centres of excellence in day surgery within the District. Procedures could include minor ophthalmology, endoscopy, flexible cystoscopies, and gynaecological procedures. Planned caesarean sections will continue to be provided, while emergency caesareans will be delivered as part of the tiered networked maternity service.

There will be a focus on day only, minor, and some common/intermediate surgical procedures. The operating space will need to be flexible to accommodate additional specialties, and scope reprocessing capability.

There will be an enhancement in other services to support the perioperative services. This will include Pathology, Pharmacy and Medical Imaging. Facilities with close observation capability including remote monitoring will allow for more complex procedures to be performed.

Mobile x-ray in the OR will allow urology stents and minor orthopaedic procedures such as arthroscopies to be performed. Easy access to cross-matched blood on site to support the perioperative service will be integral to the uplift of surgical services.

7.7 Perioperative Services Projected Activity

Base Case

Assumes models of care and patient flows will remain largely unchanged to the existing service activity profile.

The base case indicates that surgical and procedural activity will decrease from 24 episodes in 2015/16 to 21 episodes in 2036. This would reflect a decrease in beds required from 0.5 beds in 2015 to 0.2 bed in 2036. Average length of stay is proposed to be 3.5 days.

Table 47: Projected Surgical Activity at Temora Hospital 2015/16 to 2036

	Episodes					Bed Days					Beds				
Stay Type	2015	2021	2026	2031	2036	2015	2021	2026	2031	2036	2015	2021	2026	2031	2036
Day Only	5	3	3	4	4	5	3	3	4	4	0.0	0.0	0.0	0.0	0.0
Overnight	19	15	15	13	17	130	60	54	52	62	0.5	0.2	0.2	0.2	0.2
Total	**24**	**18**	**18**	**17**	**21**	**135**	**63**	**57**	**56**	**66**	**0.5**	**0.2**	**0.2**	**0.2**	**0.2**

Source: HealthAPP base case

It is predicted that the largest proportion of surgical activity for the residents of Temora and surrounds will be provided in private facilities (54%) and WWBH (25%).

Table 48: Projected Surgical Activity by treating hospital 2015/16 to 2036

Treating Hospital	2015	2021	2026	2031	2036	% of total activity
Private DPC	914	928	963	969	979	36%
Wagga Wagga(exc CC)	678	669	678	657	680	25%
Private hospitals	552	538	549	515	516	19%
Griffith	118	105	107	108	111	4%
Wagga Wagga(CC)	90	92	107	100	97	4%
Young	65	63	57	61	59	2%
Temora	64	40	40	40	42	2%
ACT Hospital	40	37	36	38	37	1%
St. Vincents - Public	29	27	31	35	36	1%
Cootamundra	36	34	34	31	24	1%
Victorian Hospital	10	14	13	11	19	1%
Other	124	103	113	103	104	4%
Grand Total	**2,720**	**2,650**	**2,728**	**2,668**	**2,704**	**100%**

Source: CaSPA HealthApp
Includes Temora + Bland + Lake Cargelligo Residents

Scenario

MLHD is keen to look for opportunities for surgical sites such as Temora to undertake less complex surgery otherwise allocated to WWBH. Increasing volumes and types of procedures being provided will require a corresponding increase in capacity.

An exercise has been undertaken to identify appropriate activity in the specialities of orthopaedics, ophthalmology, endoscopy, laparoscopes, urology, and gynaecology that could be provided at Temora in the future.

This exercise has been undertaken in two parts due to the differing catchments for specialties. For ophthalmology it is proposed that this specialty is moved to Temora from WWBH, except for patients with high anaesthetic risk in line with role delineation levels. The catchment for this service is wider, including the mid and upper eastern parts of the LHD that have reasonable access to Temora, or who would usually flow to WWBH. These LGA's include Wagga Wagga, Gundagai, Tumut, Lockhart, Coolamon, Junee, Tumbarumba, Temora, Bland, Lake Cargelligo (in line with HealthAPP groupings), Young, Boorowa, Harden and Cootamundra.

Table: 49 Projected total ophthalmology demand for residents from Gundagai, Tumut, Lockhart, Coolamon, Junee, Tumbarumba, Temora, Bland, Lake Cargelligo, Wagga, Young, Boorowa, Harden and Cootamundra (based on HealthAPP grouping) by treatment group

Sum of Episodes	2020/ 2021	2025/ 2026	2030/ 2031	2035/ 2036
50 - Ophthalmology				
Wagga Wagga (exc CC)				
503 - Glaucoma & lens procedures	382	423	469	498
509 - Other eye procedures	101	110	138	153
Wagga Wagga (exc CC) Total	**483**	**533**	**607**	**651**
Wagga Wagga (CC)				
503 - Glaucoma & lens procedures	94	96	104	114

Sum of Episodes	2020/ 2021	2025/ 2026	2030/ 2031	2035/ 2036
509 - Other eye procedures	2	4	4	4
Wagga Wagga (CC) Total	**96**	**100**	**108**	**118**
50 - Ophthalmology Total	**579**	**633**	**715**	**769**
Total daily procedures based on 250 operating days per year	**2**	**3**	**3**	**3**
annual change % baseline		**9.3**	**0.8**	**0.5**
rebase on 2020/21 actuals using annual baseline change	**747**	817	823	828
Rebased projected ophthalmology daily procedure demand based on 250 days/year operating days	**3**	**3**	**3**	**3**

Source: NSW HealthAPP

The above equates to one to two lists per week based on 7-8 patients per list. Private day procedure centre demand reversal was not included in this scenario, as this is unlikely to flow to Temora (no VMO incentive to encourage patients to go private in public facility).

The scenario for other Enhanced Service-Related Groups (ESRG's) noted above (excluding ophthalmology) is based on a smaller catchment including Temora, Wagga Wagga, Bland, Coolamon, and Junee who historically flow to WWBH, Wagga Wagga Collaborative Care services, and Temora Hospital. Current activity at Young and Cootamundra hospitals has not been considered in this scenario.

The proportion of projected activity (separations) for the remaining selected surgical and procedural Enhanced Service-Related Groups (ESRGs) which are able to be undertaken at Temora ranges from 46% for some ESRGs such as wrist and hand procedures to 95% for others such as gastroscopy. This reflects the role delineation able to be attained for these specialties at Temora. Relevant gynaecological ESRG's are included, while caesarean sections are considered as part of the maternity projections.

Table 50: Projected relevant adult day only ESRG's for MLHD LGA residents from Bland, Coolamon, Junee, Temora, and Wagga Wagga at WWBH, WW Collaborative Care and Temora hospitals

Sum of Episodes	2021	2026	2031	2036
Wagga Wagga (exc CC)	**1587**	**1693**	**1772**	**1859**
152 - Gastroscopy	343	382	403	443
161 - Diagnostic colonoscopy	353	375	393	417
162 - Diagnostic gastroscopy	167	183	189	193
492 - Wrist & hand procedures incl carpal tunnel	127	129	137	138
511 - Microvascular tissue transfer/skin grafts	42	46	52	59
512 - Skin, subcutaneous tissue & breast procedures	159	167	181	189
549 - Other general surgery	182	190	201	209
711 - Abortion w D&C, aspiration curettage or hysterotomy	29	26	27	24
712 - Endoscopic proc for female reproductive system	20	18	16	15
713 - Conisation, vagina, cervix & vulva proc	43	49	45	45

714 - Diagnostic curettage/hysteroscopy	63	66	63	67
719 - Other gynaecological surgery	59	62	65	60
Wagga Wagga (CC)	**1**	**1**	**2**	**1**
549 - Other general surgery	1	1	2	1
Temora	**1**	**1**	**1**	**1**
711 - Abortion w D&C, aspiration curettage or hysterotomy	1	1	1	1
Grand Total	**1589**	**1695**	**1775**	**1861**

Source: NSW HealthAPP

The projected total for 2020/21 is lower than selected DRG's for actual 2020/21, and excludes reversal of private day procedure centre demand, as this is unlikely to flow to Temora (no incentive for VMO's to encourage patients to go private in public facility). Rebased projections based on actual demand for 2020/21 are provided below.

Table 51: Projected relevant adult day only procedure calculations

	2020/2021	2025/2026	2030/2031	2035/2036
Total projected day only procedures	1589	1695	1775	1861
Total daily procedures based on 250 operating days per year	6	7	7	7
annual change % baseline		6.7	4.7	4.8
rebase on 2020/21 actuals and use annual baseline change	1,675	1787	1871	1962
Rebased projected daily procedure demand for ESRG's in table above	**7**	**7**	**7**	**8**

The rebased projected daily procedure demand equates to 35 procedures per week by 2031, or four to five full day (6-7 hours) lists per week based on 7-8 procedures per list. With the addition of the ophthalmology demand of one to two lists per week, Temora's projected procedure demand will be up to 10 lists per week, non-inclusive of planned or emergency caesarean sections, which will require an additional operating space to manage emergency demand without interrupting the planned day surgery schedules, particularly as these will, for most specialties, be delivered by visiting surgeons from Wagga Wagga.

Facility Requirements

An appropriate procedural/surgical centre with pre-admission clinic, pre-procedural preparation, operating theatre, procedure room with general anaesthetic capabilities, anaesthetics and post-procedural recovery areas will be provided.

It is proposed that there will be 1 X operating theatre capable of undertaking a range of procedures as outlined above. As well there will be a procedure room with general anaesthetic capabilities which will enable procedures to be undertaken either by GPs or visiting surgeons that do not require a full sterile environment. Appropriate reprocessing services will support the theatre complex.

8. CLINICAL SUPPORT SERVICES

8.1 VIRTUAL CARE – CURRENT AND PROPOSED

Virtual care is guided by eHealth NSW (eHealth Strategy for NSW Health 2016-2026), which guides LHD's with planning and strategies for virtual care and other electronic support mechanisms/tools such as eReferral, Single Digital Patient Record etc.

Temora Hospital has Telehealth outreach services that are linked with Coolamon, West Wyalong, Junee and others. Inreach services include aged care, rehabilitation, Mental Health & Drug & Alcohol and Geriatrics.

The ED has a critical care Telehealth system linked with the Critical Care Advisory Service through MLHD Patient Flow Unit. As well there is critical care over bed network in Maternity. An additional Telehealth unit is available; however Mental Health has priority for this equipment. It can be used at other times for education and other Telehealth consultations.

The vision for NSW Health is a sustainable health system that delivers outcomes that matter to patients and the community, is personalised, invests in wellness, and is digitally enabled. The NSW Virtual Care Strategy outlines the steps that will be taken to further integrate virtual care as a safe, effective, accessible option for healthcare delivery in NSW.[30]

Virtual Care has been defined 'as any interaction between a patient and clinician, or between clinicians, occurring remotely with the use of information technologies. As technology has evolved so too has our terminology, and 'Telehealth' services are increasingly being referred to as 'Virtual Care' to better reflect the broader range of technologies'[31].

Virtual Care can include remote monitoring, videoconferencing, virtual examination, 24/7 senior clinical consultation, patient communication, family meetings, Virtual Care to peripheral sites, meetings as well as education and just-in time instructions.

Virtual Care will continue to be rolled out across MLHD to provide support to critical clinical and corporate functions. The technology will support a range of clinical and clinical support services such as telePathology, telePsychiatry, telePharmacy to name but a few.

Virtual Care services will also expand to meet the needs of increased outpatient, outreach and community-based services. Virtual Care modalities will be required to provide links to specialist services within and outside MLHD.

A range of different technologies will be introduced to facilitate this rollout. These include but are not limited to:

[30] NSW Health: The Virtual Care Strategy 2021-2026 – Connecting patients to care. https://www.health.nsw.gov.au/virtualcare/Publications/nsw-health-virtual-care-strategy-feb-2022.pdf
[31] NSW Health: The Virtual Care Strategy 2021-2026 – Connecting patients to care. https://www.health.nsw.gov.au/virtualcare/Publications/nsw-health-virtual-care-strategy-feb-2022.pdf

- Cameras for wound care, photos etc
- Teams – photo - linked to patient number in eMR
- My Virtual Care with adequate WiFi – high definition, iPads
- Remote care to inpatients - piggy backed
- Specialist consultation- requires high-definition camera – 3-4 per site – mobile could be integrated into mobile computer trolleys
- Apps and self-monitoring capacity for remote patients

The rollout of Virtual Care has many advantages. An example is if allied health resources supporting rehabilitation services are not on site, staff including Allied Health (AH) Assistants can have off site supervision and assistance with links to AH professionals.

There are issues impacting on the rollout of Virtual Care across MLHD. These include but are not limited to:

- access and equity require readiness with suitable equipment and support for both patients/clients/consumers and staff
- digital literacy with an adversity to change for patients and staff
- problems with IT connectivity across the regions
- good accountability to make the shift as well as incentives
- efficiency and cost effectiveness need to be determined
- resourcing of both the virtual hubs and local spokes – currently there are 30 virtual hubs across sites in both hospitals and outpatient services
- gap in rollout due to CoVID-19

It is proposed that Virtual Care facilities should be close to the front access of the facility to allow for outpatients to have easy access to them when needing to attend virtual specialist appointments or other Virtual Care initiatives.

8.2 MEDICAL IMAGING – CURRENT AND PROPOSED

Temora Health Service provides a Radiographer service five days per week with on call access for emergency x-rays. It has a fixed x-ray unit with a Bucky table and designated x-ray room. There are no remote operator Nurse or GP imaging services.

The X-ray equipment was replaced in 2015 with Picture Archiving and Communication, and Radiology Information System (PACS/RIS) hardware. Films are currently read and reported at Regional Imaging in Albury by a Radiologist as part of a MLHD contract. Currently reports are faxed back to the site and a hard copy stored. These will be replaced by digital copies as the system is digitised.

Residents have access to ultrasounds and CT scans at Qscan Temora (formerly Alpenglow Australia Temora Diagnostic Imaging), a private radiology provider. For public ultrasound and CT scans, patients are transferred to WWBH, which is costly for the health service in terms of travel requirements, delays diagnostics and has impacts for patients and their families.

In the years 2018/19 to 2021/22 (YTD), the demand for private CT services for Temora residents shows an increase from 58 procedures per annum to 100 procedures for 8 months. This equates to an annual increase in services of 225% pa (2021/22 has been extrapolated for the full 12 months = 150 procedures).

In the years 2018/19 to 2021/22 (YTD), the demand for private ultrasound services shows an increase from 29 procedures per annum to 41 procedures for 8 months. This equates to an annual increase in services of 28% pa (2021/22 has been extrapolated for the full 12 months = 62 procedures in the table below). Updated private demand data for 2021/22 indicates demand for CT was 122 for Temora residents and 153 for outlying areas, while ultrasound (US) was 55 for Temora residents and US 15 for outlying areas. The first six months of the 2022/23 period indicates further growth with CT demand for Temora residents 68 (136 annual), and 35 (70) for outlying areas. US growth is also evident for Temora residents (34 or 68 annual).

Table 37: Temora third party service provider imaging activity by Modality 2018/19 to 2021/22

Year	Modality	Number
2018/19	CT	15
	Ultrasound	0
2019/20	CT	58
	Ultrasound	29
2020/21	CT	99
	Ultrasound	49
2021/22 (YTD)	CT	100
	Ultrasound	41

Source: MLHD Medical Imaging Radiology Information System (RIS)

In addition to the private demand noted above, demand for both CT and US by Temora and West Wyalong residents at Griffith and Wagga Wagga Base hospitals is shown below. CT activity at GBH has seen a shift to more outpatient demand, while at WWBH the majority of demand remains inpatient, possibly reflective of transfers to WWBH which may have been unnecessary. It would be anticipated that demand will increase over time partly from people who can't or won't pay the gap charged by private providers, who generally do not bulk bill.

Table 53: CT services for Temora and West Wyalong residents at WWBH and GBH

Row Labels	2018	2019	2020	2021	2022	Grand Total
Griffith Base Hospital	**70**	**172**	**150**	**215**	**183**	**790**
E	25	39	39	59	52	214
I	26	71	70	90	56	313
O	19	62	41	66	75	263
Wagga Wagga Base Hospital	**393**	**753**	**769**	**851**	**819**	**3,585**
E	41	88	93	145	127	494
I	331	630	644	662	661	2,928
O	21	35	32	44	31	163
Grand Total	**463**	**925**	**919**	**1,066**	**1,002**	**4,375**

Source: MLHD Medical Imaging Radiology Information System (RIS) E=emergency, I=inpatient, O=outpatient

It is evident that the majority of ultrasound flows for Temora and West Wyalong residents are to WWBH and GBH rather than to Young or Cootamundra. The majority of ultrasounds at GBH are outpatient services, while at WWBH they are inpatient.

Table 54: US services for Temora and West Wyalong residents at WWBH and GBH

Row Labels	2018	2019	2020	2021	2022	Grand Total
Cootamundra Hospital	**9**	**30**	**35**	**27**	**19**	**120**
E		2	1	1	5	9
I	2				1	3
O	7	28	34	26	13	108
Deniliquin Hospital		**3**	**1**		**2**	**6**
O		3	1		2	6
Griffith Base Hospital	**93**	**193**	**163**	**199**	**176**	**824**
E	9	24	15	17	14	79
I	19	44	49	47	41	200
O	65	125	99	135	121	545
Wagga Wagga Base Hospital	**162**	**339**	**315**	**378**	**289**	**1,483**
E	6	13	16	20	20	75
I	147	295	261	307	252	1,262
O	9	31	38	51	17	146
Young District Hospital	**5**	**13**	**14**	**9**	**22**	**63**
E		1				1
I					1	1
O	5	12	14	9	21	61
Grand Total	**269**	**578**	**528**	**613**	**508**	**2,496**

Source: MLHD Medical Imaging Radiology Information System (RIS) E=emergency, I=inpatient, O=outpatient

For MLHD, there is a need to utilise outlying facilities better, and diagnostics is a key enabler for this with equity of access a key theme in the Clinical Services Framework. While private providers cater to people who can afford to pay for the service, Murrumbidgee have communities with lower-socioeconomic profiles and access to public services impacts on their ability to stay well.

CT scans are now a standard component of most radiology services (including private) and is best practice for many fractures and suspected strokes. There is a push for CT and ultrasound services to be provided at Temora Health Service with sufficient demand being identified for the provision CT and ultrasound to service residents from Temora and West Wyalong.

Access to a CT service at the facility will reduce the need for both inpatients and emergency presentations to be transported to the private provider locally or to WWBH (after hours). This would improve patient experience, patient care, and reduce cost to the health service for transport. Advantages include:

- Most CT exams currently performed at WWBH and GBH for Temora/ West Wyalong residents could be performed at Temora. This would reduce burden on both Base Hospital radiology departments and patient flow, better utilising Temora inpatient beds.

- There would be an increase in outpatient activity at Temora as this service would be bulk billed, the community would use the public hospital rather than be out of pocket at the private provider. Currently approx. 50% of Temora radiology activity is for outpatients, this would assist with revenue
- Reduced referrals to the private radiology service in Temora would reduce costs for MLHD

Temora would see similar activity levels to Tumut Hospital new CT service.

Ultrasound will also be required on site. This will support the uplift of Maternity services as well as other clinical services. The preferred model is for a public service run by MLHD.

The level of the General X-ray service is also likely to change in the first year, from the current level; during which there may be a natural increase in services; due to the availability of the other modalities and the run-on effect of follow up X-rays, post CT etc, for fractures.

The provision of Orthopantogram and Lateral Cephalogram (OPG/lat ceph) should be considered. From 1 January 2019 to 30 June 2022, there was a total of 531 referrals received from the local Temora dentists and visiting orthodontist; Young District Hospital undertook the majority of imaging (approximately 58%), while WWBH performed approximately 39% of referrals with the remaining 3% performed at Griffith Base Hospital.

Table 385: Temora third party service provider OPG/Lat Ceph activity 2018/19 to 2021/22

Year	Number of Referrals
2018/19	99
2019/20	163
2020/21	196
2021/22	73
Total	**531**

Source: MLHD Medical Imaging Radiology Information System (RIS)

N.B. these stats only relate to patients who have presented to any of the 4 MLHD sites, it does not capture any patients who have been imaged using the private imaging sector.

Workforce governance and additional training will need to be considered as future medical imaging services evolve.

8.3 Pharmacy – Current and Proposed

Pharmacy supplies for inpatients are provided from MLHD Pharmacy Unit on a weekly basis using an imprest system. Medications are ordered by nursing staff through a Pharmacy portal. TelePharmacy is available to clinicians for any issues relating to the ordering and administration of medications. A clinical pharmacist from Young visits the hospital once per week via the MLHD pharmacy outreach service. There are three private Pharmacies in Temora.

It is proposed that pharmacy services at Temora Health Service be increased to RDL 3 to enhance the uplift of some medical and surgical service levels to RDL 3. This requires a dedicated pharmacy space compliant with the Pharmacy Council and a pharmacist on site. This will require an onsite imprest system and availability of medications to support the patient care areas. Alignment with eHealth projects such as ePrescribing and Single digital Patient Record are recommended

Pharmacists play an important role as part of the multidisciplinary healthcare team. Increasingly medication management is being enhanced using technology including medication systems, bar coding and TelePharmacy.

Pharmacy services will be provided to all inpatient and ambulatory patients. The service provides a range of services including:

- dispensing to inpatient and ambulant patients
- provision of clinical support to clinical units
- discharge planning
- drug monitoring, information, and advisory services
- consultation with ambulatory and discharge patients (patient counselling, drug information)
- patient advisory services including admission and discharge planning, liaison with community providers, counselling, and compliance monitoring
- controlled storage, recording and distribution of narcotics and accountable substances
- utilisation review and adverse drug reactions reporting
- quality programs including antimicrobial stewardship
- staff education and training and
- purchasing, dispensing and distribution of drugs to the point of usage.
- Facilities for the storage, preparation and issuing of pharmaceuticals will be provided at all patient contact points.
- Delivery of medications to the loading dock must allow for secure storage pending transport of supplies to patient care areas.

8.4 PATHOLOGY – CURRENT AND PROPOSED

Public Pathology services at Temora Health Service are provided by NSW Health Pathology (NSWHP). NSWHP is a state-wide government pathology service with provision for Temora and surrounds being part of the NSWHP Regional and Rural network, which is responsible for operational management. NSWHP Regional and Rural network provides services to a large geographical area including the Western NSW, Far West, Murrumbidgee, and Southern NSW Local Health Districts.

Temora Health Service is supported on site with Point of Care Testing (PoCT) technology for rapid diagnostic testing, as well as a sample collection service.

Core laboratory services consist of blood bank, haematology, and chemical pathology services are available through PoCT or via the Cootamundra laboratory.

Pathology specimens that require more complex testing are referred to other NSWHP laboratories at either WWBH or Westmead Hospital.

New developments in pathology include:

- Increasing use of PoCT with an expanding test profile, and with increased consolidation of high cost and/or specialised services
- Increasing convergence of disciplines and shared use of staff and equipment
- Increasing specialisation of sub-specialties with unique equipment and
- Increasing automation of services and transition to digital pathology[32]

Rapidly changing patterns of pathology practice and evolving technology will have a big impact on how pathology services are provided in the future. The use of automated equipment and information technology being provided is increasing rapidly in response to higher volumes of testing, the need for faster turnaround times as well as workforce challenges and cost pressures[33].

The future model of clinical service delivery for Temora Health Service will see an overall impact on pathology services which will be a proportionately higher volume of samples for processing and a greater emphasis on turnaround times due to shorter care episodes for patients. As diagnostic requirements develop, NSWHP will adopt appropriate technologies and pathways to deliver suitable pathology services and scope of testing.

A RDL 3 pathology service is required to support the proposed uplift of several clinical services to level 3 particularly maternity and surgery. NSWHP have proposed that should a larger laboratory be located within the region with a greater scope of testing than offered in the existing Cootamundra laboratory as well as improved turnaround times then access to enhanced services could be possible. The ability of pathology service technology enhancements to meet the NSW Health Guide to Role Delineation of Clinical Services requirements for services proposed to be delivered at Temora Health Service needs to be investigated.

Changes to the current test menu are reviewed annually as part of the Customer Charter (NSWHP/Murrumbidgee LHD) and will reflect the clinical requirements of Temora Health Service.

Enhanced PoCT provision of testing, integrated with hospital services, will provide rapid near patient testing in acute clinical settings. This will be supported by networked arrangements, increased logistics/couriering, remote test and blood product management, and pathology collections. Subspecialty services such as Infectious Disease management and Clinical Haematology will be delivered across MLHD through networked resources.

There will be on site solutions for regional and rural settings consisting of increased availability of PoCT aimed at reducing call-backs for laboratory staff. Point of care testing will continue to be available 24 hours, seven days per week in ED.

[32] Australasian Health Facility Guidelines 0550 – Pathology Unit Revision 7.0 May 2022 p9
[33] Et p10

Smart blood fridge management for blood and blood products will be introduced across MLHD. This system aims to reduce wastage of blood and blood products.

There are continuing technological changes to pathology services with expanding and new devices every year. All ordering and reporting of pathology tests will be completed digitally to enhance faster turnaround of results. This will reduce costs for pathology and MLHD by reducing waste and duplication of tests.

The enhancement of Virtual Care and TelePathology services will improve access to specialist pathology services to support patient care.

For MLHD, it is recommended that consideration be given to a pathology laboratory being included in the scope of any future infrastructure development. This is subject to agreement and support from NSW Health Pathology. MLHD will undertake further discussion with NSW Health Pathology during facility planning and change management.

8.5 Sterilisation Services – Current and Proposed

Sterilisation services will continue to be provided through WWBH. Service frequency is dependent on need. With the uplift in both Surgical, Maternity and outpatient procedural services, all of which are heavily reliant of sterilising services, there will be an increased demand for sterilising services in both stock and equipment levels as well as turnaround times.

Adequate space for storage of sterile stock and equipment in appropriate clinical areas will need to be considered in any future facility planning. As well areas for cleaning of equipment prior to return to CSSD, and on-site reprocessing requirements will need to be considered.

8.6 Stores Management – Current and Proposed

Stores are ordered through a centralised stores ordering system in Sydney. Stock levels are maintained at a level where shortages and expiry are avoided. Stores management systems will continue through MLHD centralised management systems.

8.7 Non-Clinical Support – Current and Proposed

8.7.1 Mortuary Services

Funeral Directors generally collect bodies directly from the cool room. The cool room has capacity for two trolleys.

The absence of a viewing room for the deceased was noted as an issue. From a cultural perspective the association of death with inpatient or emergency department settings impacts on future access. A viewing room able to be accessed externally with a small adjoining garden area is ideal to meet the cultural requirements of the local community.

Sorry spaces for family groups are being introduced at a number of MLHD sites and should be included at Temora.

8.7.2 Maintenance Services

A handyman based at Temora provides grounds maintenance. Trade services are provided through Young maintenance staff.

The endorsed operational model for the MLHD Asset Management Unit is focussed on a local service supported by a centralised business unit with common management strategies, tools and systems. Asset management using the NSW Health Total Asset Management strategy, essentially operates across five (5) streams, these are summarised as:

- Operations (Engineering).
- Biomedical Engineering.
- Governance (Asset Performance and Compliance).
- Property; and
- Capital Works (including Energy Management).

On-site maintenance services will continue to be provided both locally and more globally via the district-Wide support network dispersed across the Asset Management Unit.

There is also reliance for other trade and specialist resources, and these are provided via Local Health District Contracts, internal and external resources, and service providers. MLHD is currently implementing a new State-wide Asset Management System (AFM Online) which is used for reporting and forecasting the most effective and efficient service delivery models.

8.7.3 Waste Management

Waste is separated on site. General waste is collected three times weekly by Cleanaway while Daniel's HealthCare collects clinical waste once a month. Council collects recycling weekly. Waste will continue to be separated on site with contracted services for general and clinical waste.

Increases in maternity and surgical activity will require a clinical waste management review.

8.7.4 Catering, Cleaning and Linen Services

Catering, Cleaning and Laundry services are currently provided through an MLHD contract with HealthShare NSW. HealthShare NSW has one office within the facility. Linen delivery is weekly from Wagga Wagga. The kitchen provides cook/chill meals and can provide light meals for inpatients as required.

HealthShare NSW has advised that the future delivery and management of these services will be changed over time with the introduction of new technology. All of these measures are aimed at increasing sustainability and reducing costs.

<u>Catering:</u>
Currently HealthShare NSW provides cook/chill meals and can provide light meals for patients as required.

The introduction of the order/appetite model will enhance the patient experience and reduce food wastage. This is a flexible system with the ordering of foods to align with patient's needs. A health app will be available within 2 years to facilitate this process. The model is currently being piloted at Bowral Hospital and is expected to be rolled out across the state.

It is advised that any kitchen facility upgrade allow for a flexible design with reduced fixtures and walls. This will minimise the need to do major refurbishments when new technology and models of service delivery are introduced.

It is proposed that an integrated IT system be included in either the phone or TV system for each bed to allow patients to access the ordering systems.

Cleaning:

Technological advancements will lead to new ways of cleaning both clinical and non-clinical areas within hospitals. New cleaning technology will be considered in consultation with HealthShare NSW, to decontaminate and clean areas including patient's rooms, kitchens etc. This technology will reduce the transportation, use and storage of chemicals which will lead to improved patient and staff safety. It will increase the life of the building particularly floors and walls by reducing the use of harsh chemicals.

Adequate storage for cleaning machines in the cleaner's rooms will be essential.

There will be a shift to electronic ordering which will enhance inventory control, reduce wastage, and reduce costs.

Linen Services:

These will continue to be delivered every 3 days so adequate storage for both clean and dirty linen is essential.

These arrangements may need to be reviewed in the future to increase storage capacity and reduce frequency to address increasing transport costs.

Loading Dock:

Adequate loading dock facilities will need to be provided to allow for the delivery and storage of goods and consumables passing through the dock area.

8.7.5 Spiritual Care:

A dedicated space will be provided for reflection, retreat, spiritual and religious observances.

Multiple studies have demonstrated the benefit of having a quiet space where family members, staff and visitors can pray / grieve / collect their thoughts.

9. OPTIONS FOR FUTURE DEVELOPMENT

Options identifying changes to the current capital stock were investigated as part of this planning process. These were intended to identify physical infrastructure requirements needed to achieve future service models outlined in this plan. This includes the uplift of a number of clinical services and clinical support services as well as changes to models of care. The ability to enhance contemporary models of care and service delivery will allow for the Temora Health Service to better meet the community's future health needs and optimise efficiency and effectiveness.

Changing models of service delivery for some of the nonclinical services will also require changes to the facilities to allow for their introduction.

The optimisation of Virtual Care at Temora is aimed at achieving the vision for NSW Health to a more sustainable health system that delivers outcomes that matter to patients and the community, is personalised, invests in wellness, and is digitally enabled. This is a key objective in any planning exercise for Temora Health Service.

The five options are outlined below:

Table 5639: Options identified for Temora Health Service

Option	Description
Base case option	- Status Quo – keep safe and operating - No change to patient flows - Lack of infrastructure to accommodate uplift of services - Limited ability to accommodate contemporary models of care
Noncapital solution	- Outsource services - Contract services to other service providers - Noncapital solutions cannot deliver the growth in service demand and are not consistent with NSW Ministry of Health or Temora CSP objectives (e.g. provide services where they are needed, provide equity of access).
Enhanced Virtual Care within existing facilities	- Upgrade IC&T infrastructure to enable optimal utilisation of Virtual Care - A recent exercise to upgrade IC&T at Temora was undertaken and it was deemed cost prohibitive because of the current building which is double brick and has asbestos
Refurbishment of existing facilities	- A total upgrade of the current facilities would be required to meet contemporary building standards - The facility would potentially need extensive refurbishment to meet all the objectives outlined in the Plan - As mentioned above, the current building has a number of major challenges
Facility Redevelopment	- New facility - Will achieve medium to long term capacity requirements and allow for flexibility to allow for future changes to service delivery and clinical practice as well as technological advances

10. HEALTH RELATED TRANSPORT – CURRENT AND PROPOSED

10.1 EMERGENCY TRANSPORT

There are Ambulance stations in Temora, Tumut, Batlow, and Tumbarumba which service the Snowy Valleys region. There is also a station at Gundagai. NSW Ambulance provides a backup for non-health related transport when required.

NSW Ambulance will continue to provide emergency transport to Temora Health Service and provide inter-hospital transfers where appropriate.

NSW Ambulance will continue to bypass Temora to higher level services as required. Temora is not a declared mental health facility. All scheduled patients will only get transferred to a declared facility. Despite not being a declared facility, walk in emergency department presentations for mental health related issues do occur. Ambulance transfer of these patients is informed by a Memorandum of Understanding between NSW Ambulance and MLHD. People with mental health conditions requiring further assessment or admission will in the first instance be transferred to WWBH.

NSW Ambulance will continue to provide a backup for non-health related transport when required.

Aerial health related retrievals/transfers are generally via helicopter from the helipad located at the airport. Aerial transfers are organised through the Patient Flow Unit.

10.2 OTHER HEALTH RELATED TRANSPORT

Patient transport vehicles are based in the Wagga Wagga transport pool which can be accessed for non-urgent medical transfers. A fleet car is used to transport dialysis patients three days per week to Wagga Wagga. There is one patient transport vehicle allocated to Temora.

MLHD transport vehicles will continue to provide non urgent patient transfers, including transfers from WWBH to Temora for slow stream rehabilitation, medical and surgical services.

MHDA have two designated cars for mental health crisis transfers. These cars are required to be always available. One is a four-wheel drive to allow access of properties with four-wheel drive only access.

The MLHD Patient Flow Unit assists sites to organise transfer of patients to and from MLHD sites and to higher level services in NSW, ACT or Victoria. This includes organising the most suitable transport and checking bed availability. The current service operates from 7am to 7pm but will be extended to 11pm.

11. PRIMARY CARE

11.1 GENERAL PRACTICE SERVICES

There are three GP practices in Temora: Temora Medical Complex, Victoria Street Surgery, and a private practice. Details of GP's and services provided by private services and Murrumbidgee Primary Health Network (MPHN) are shown in the table below. All of the GPs at the Temora Medical Complex have visiting rights to the hospital.

Table 57: General Practice Services in Temora

Service	Temora Medical Complex	Victoria Street Surgery	Private Practice	Murrumbidgee Primary Health Network
Aboriginal Services				visiting
Aged Care			X	
Audiometrist	visiting			
Chiropractic			X	
Chronic Disease Care	X	X		X
Counsellor	visiting			
Dentist			X	
Diabetes Educator	visiting	visiting		visiting
Dietitian	visiting	visiting		visiting
General Surgery	visiting X 2			
GP's	6	1		
Mental Health Services	X	X	X	visiting
Minor Procedures	X	X		
Obstetrics	X	X		
Optometrist			X	
Orthopaedics	X 2			
Paediatric Outreach	visiting			
Parkinson's Support				visiting
Pathologist			X Douglas Hanly Moir	
Pharmacies			X - 2	
Physiotherapist	visiting		X	
Podiatrist	visiting	visiting	X and visiting	visiting
Rheumatologist				
Speech Pathologist			X	
Surgeon	visiting			
Telemedicine	X			
Urologist	visiting X 2			
Women's Health	X			

Advice at the consultations from LHAC and other attendees indicated same day appointments were generally available, particularly for urgent issues. Waiting times can be longer for a specific GP and non-urgent conditions.

Sporadic after-hours medical services are provided on some Saturdays at the Temora Medical Complex.

11.2 MURRUMBIDGEE PRIMARY HEALTH NETWORK

The Murrumbidgee Primary Health Network (MPHN) is one of 31 primary health care organisations established on 1 July 2015 with the key objectives of:

- Increasing the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes; and
- Improving coordination of care to ensure patients receive the right care in the right place at the right time.

Primary Health Networks have been set six key priorities for targeted work: mental health, Aboriginal and Torres Strait Islander health, population health, health workforce, digital health and aged care. The MPHN is working with health service providers, consumers, and communities to improve coordination of care, ensuring patients receive the right care in the right place at the right time.

The MPHN is informed by local health professionals and communities through four regionally based Clinical Councils, and 33 LHACs informing a single Community Advisory Council. The LHACs are run conjointly with MLHD.

The MPHN works with partner service providers including the MLHD, Aboriginal Medical Services, Aged Care Services, and other local providers to implement integrated/coordinated models of care, including the development of Healthcare Pathways. MPHN and MLHD have a memorandum of understanding for conjoint planning and have undertaken a detailed primary care needs assessment across the district.

The Murrumbidgee PHN Strategic Plan 2019-2022 outlines five major goals aimed at supporting their vision of well people and resilient communities. The plan has a strong focus on engagement and partnerships both with the health sector and beyond. MPHN have built on the extensive needs analysis and community health profiles developed by the previous Medicare Locals.

Development of the existing primary health service provider workforce continues to be a focus for the MPHN.

12. COMMUNITY SUPPORT AND SOCIAL SERVICES

12.1 LOCAL HEALTH ADVISORY COMMITTEE

Temora Health Service LHAC was formed mid-2014 and is made up of eight members who provide a conduit between the LHD and the community. The committee members are residents themselves who also have connections to multiple services in the community. LHAC members were well represented at the consultations to develop this service plan.

12.2 HOSPITAL AUXILIARY

The Temora Hospital Auxiliary has around 40 members of whom approximately eight to nine are active. The Auxiliary raises money for much needed equipment for the hospital. They are a valuable support for the Health Service. Meetings are held monthly. The facility manager is invited.

12.3 COMMUNITY MENTAL HEALTH AND DRUG AND ALCOHOL SERVICES

Temora has a multidisciplinary Community Health and Mental Health/ Drug and Alcohol (MHDA) team who provide equitable access to surrounding communities including Bland Coolamon and Junee Shires. These services are available across the lifespan, Child & Adolescent (CAMHS), Adults and Older Persons (SMHSOP). Temora Community Mental Health is a declared community mental health facility.

Generalist Community Health outreach is provided to Ariah Park, and Ardlethan. Centralised specialist support positions such as Clinical Nurse Consultants (CNC's), and Nurse Practitioners (NP's) provide additional advice and support when required.

The Specialist Community Mental Health and Drug & Alcohol Teams provide:

1. **Assessment:** this is an interview with a mental health clinician to identify the consumer's needs, which may also include consultation with a psychiatrist.
2. **Individual Care:** Following assessment, the mental health clinician will give information about available treatment options and reach an agreement with the consumer about a care plan. Other important people in the consumer's life may be involved in this process with the consumer's permission.
3. **Case Management:** This is offered to consumers who require further counselling, treatment, or recovery support. This includes referral and consultation with other service providers.
4. **Psychiatry Clinics**: Adult, Child and Adolescent and Older Persons Psychiatrists visit on a weekly basis
5. **Referral and Consultation:** When the initial assessment has been completed it may be necessary to refer to (or consult with) other service providers for specialist services.
6. **Education:** Education on a variety of mental health issues is provided to consumers, families, carers and community groups.
7. **Advocacy:** The Community Mental Health Service can speak with other service providers on consumers' behalf.
8. **Drug & Alcohol and Opioid Treatment program:** Aiming to reduce harm caused using drugs and alcohol. Responding to people with all kinds of use and patterns of harm, not just those with dependence. Offering education, assessment and referral to other specialised drug and alcohol services for

individuals, families, and community groups; This includes consultation with an Addiction Specialist

9. **Carer Peer Support Worker and Consumer Peer Worker:** People with Lived Experience provide support and advocacy to consumers and carers
10. **Mental Health Support Workers** work alongside the clinicians and support consumers with implementing their wellness plan
11. **Got IT Program:** Screening and Intervention in Primary schools for children who may be vulnerable to MH issues in the future

12.4 AGED AND DISABILITY SERVICES

There are several organisations that provide aged and disability services to the Temora community. Ageing, Disability and Home Care (Home Care Service of NSW), Temora CanAssist, and Kurrajong Waratah Disability Services operate from Temora, while Baptist Care provides domestic assistance and personal care and are based in Albury.

Commonwealth Home Support Programme (CHSP)

Commonwealth home support services are auspice through Pinnacle Community Services based in Temora. They provide:

- Meals on Wheels.
- Community Transport.
- Neighbour Aid; and
- Home Maintenance.

12.5 CHILDREN'S SUPPORT SERVICES

Centacare South West provides support for children and families with complex needs. Kurrajong Waratah also provide early childhood intervention services and supported accommodation services.

The Intereach ROAR (Reach Out and Relax) program is an early intervention service available in Temora, which aims to improve emotional health and wellbeing for children, young people, and their families.

12.6 SERVICE GUIDE

The Temora Council maintain an electronic service directory (DirectMe) on their website, which provides contacts for health and social services, services for older residents, the disabled and their carers, and families and children. In addition, there are contact numbers for help lines and health related websites. The Resource also contains social, leisure and cultural opportunities for residents across the Shire.

13. AGED CARE SERVICES

Temora Health Service does not provide residential aged care services, however older people are more likely to use health services, and this is reflected in the Temora service use data presented later in the document. Similarly, Community Health provides services for older residents with access to Aged Care specialist Nurses for advice and support.

Other aged care service providers are outlined below. There is currently no visiting Geriatrician service in Temora; however, MLHD have recently appointed a District Geriatrician based in Wagga Wagga. Opportunities exist to explore models to provide specialist geriatric support services.

13.1 THE WHIDDON GROUP

The Whiddon Group provides two facilities providing residential aged care in Temora: Whiddon Group -Temora and Whiddon Group - Greenstone services, with a total of 76 beds. The Whiddon Group Temora service offers 28 residential places and an additional 12 dementia specific residential places. The Greenstone service offers 36 residential places.

Both provide ageing in place and have a specific focus on people with a terminal illness, services for Aboriginal and/or Torres Strait Islander people and a focus on socially and financially disadvantaged people. The Temora facility also offers services for veterans, and people from Culturally and Linguistically Diverse backgrounds (CALD). People with dementia are provided for at both facilities, with specific places offered at the Whiddon Group Temora service.

13.2 SOUTHERN CROSS CARE

Southern Cross Care provides 24 independent living units and a shared recreation room.

13.3 AGED CARE ASSESSMENT TEAM (ACAT)

ACAT assess clients to determine their care needs and eligibility for accessing Australian Government funded aged care services, including Home Care Packages, TACP and residential aged care. The ACAT Nurse covering the Temora Shire is based at Temora and reports through Wagga Wagga.

13.4 HOME CARE PACKAGES

Home Care Packages are now allocated to the client and then the client accesses the service provider they want. The client will be added to a waiting list to await placement when a vacancy occurs.

Home Care Package providers are covering larger geographic areas and may not be based in the community they provide care in. Rather, local workers are engaged to provide care in smaller communities. For Temora there are 16 providers of level 1 and 2 packages, and 21 providers of level 3 and 4 packages. Anecdotally there has been reduced demand for lower-level packages since Commonwealth changes to eligibility and means testing were introduced in 2014. Consumer Directed Care commenced on 1 July 2015, with further changes in February 2017.

14. PRIVATE SERVICES

There are multiple private health services operating in various settings in Temora as follows:

- Aged Care.
- Chiropractic.
- Dentist.
- Mental Health Services.
- Optometrist.
- Pathologist – Douglas Hanly Moir.
- Pharmacies (2).
- Physiotherapist.
- Podiatrist; and Speech Pathologist.

15. WORKFORCE

The current staff mix meets emergency and inpatient needs. Community health demand is exceeding workforce capacity, with some programs having to develop strict criteria to focus on priority areas to manage waiting lists. Community drug and alcohol programs have seen increasing demands. Vacancies exist for some services and recruitment can take time.

Current Workforce Profile

- Currently there are 66 employees in the Temora Health Service workforce. The contracted FTE equates to 35.95.
- 3.0% of employees identified as Aboriginal or Torres Strait Islander.
- 8 of the 66 staff are casual.
- 52.9% of the nursing workforce carries excessive leave liability. (Excessive leave is defined as leave days > 30).
- 7.5% of nurses within the Health Service are over or within 5 years of the average retirement age; and
- 48.7.5% of all female nursing staff are of traditional childbearing age (20-40 years).
- 28.8% are 50 years or older.

Midwives make up 12 of the 66 employees (18%) - three are full time, seven are part time, and two are casual.

Future Workforce Profile

A reorganisation of existing workforce will be required to meet the increasing shift and development of outpatient, community, and ambulatory care services. Enhancements may be required to meet the service changes. Collocation of the outpatient centre services will provide efficiencies for administrative support.

Staffing levels for the future Temora Health Service will need to cover:

- RDL 3 Emergency Department.
- Level 3 Maternity Service.
- Level 2 Neonatal service.
- RDL 3 Rehabilitation Service.
- 24 inpatient beds.
- Outpatients, community health and home-based care Aboriginal Health program delivery.
- After hours GP service.
- RDL 3 radiology service.
- RDL3 pathology service; and
- RDL 3 pharmacy service.

The MLHD Workforce Planning Team will work with the Temora Cluster Manager, Facility Manager and Stream Managers to develop a Workforce Plan to meet recommended service delivery requirements.

The Nursing and Midwifery Directorate will be engaged to establish skill mix requirements based on the relevant current Award determinations, to reflect the Public Health System Nurses' and Midwives' (State) Award requirement Clause 53 section 111 for D1a Community Hospitals with surgery.

Other Stream/ Directorate managers requiring input include the Executive Director Medical Services, Director Allied Health, Director Mental Health/ Drug and Alcohol, and Manager Aboriginal Health. Visiting Specialists from WWBH will need to be consulted about models of care and any local workforce implications.

Staff Accommodation

One of the biggest issues affecting the current workforce is staff accommodation or lack thereof. This has a major impact on the health service's ability to attract and retain staff. There are currently very few properties in town either for purchase or rental. Suitable short term and long-term accommodation is a major draw card for attracting workforce. The provision of short-term accommodation on the hospital campus is used to accommodate new staff in the short term, visiting staff, staff rotating from other sites and agency staff. The provision of accommodation needs to be flexible to meet the changing needs of the hospital staff. Existing accommodation is dated and does not meet current standards. Only five of the existing 10 bed capacity are suitable for use as some of the old nurses home has been decommissioned. Current occupancy of the five available beds is 100% the majority of the time. It is proposed that 8 to10 units are provided to meet future staff requirements. The accommodation will continue to be used for locum nursing and medical staff, student placements, visiting medical staff, and short term for people relocating to the town (12 weeks).

Education and Training

It is proposed that a Charles Sturt University (CSU) School of Rural Medicine presence be established on the Temora Health Service campus. This is part of a Federal Government commitment to expanding medical education in regional Australia. Students will learn through experience and immersion in a broad range of hospital and community-based services throughout the program.[34]

Technological linkages between various health sites and the university campuses will be integral to ensuring an optimal learning environment for the students.

The facilities that will be required to accommodate the school include:

- 1 X group education room
- Student's lounge
- Storage for education resources including simulation models
- Staff accommodation
- Virtual Care infrastructure

[34] Charles Sturt University School of Rural Medicine science-health.csu.edu.au/schools/medicine/home

16. SERVICE GAPS AND OPPORTUNITIES

Several gaps and opportunities were raised at consultations for Temora Health Service as follows:

- A facility with good functional relationships which supported patient privacy, and staff and patient safety.
- After hours GP services.
- Virtual Care to support all services including community health/ outpatient services and the GP on call model.
- Rehabilitation services to allow early return from higher level services from WWBH and other NSW services including pulmonary and cardiac rehab programs and allied health staff.
- Access to more allied health services including Occupational Therapy and Podiatry services.
- More accessible renal dialysis services (currently available at WWBH, Tumut and Cowra).
- Community based outreach, outpatient and hospital avoidance models of care.
- Weekend and after-hours community palliative care services and inpatient end of life care infrastructure for patients and relatives.
- A local cancer survivor service.
- Mental Health and Drug and Alcohol services to meet increasing demand –
    - Youth, specifically child and adolescent Psychologist and Social Work availability.
    - Aboriginal specific Mental Health and Drug and Alcohol services.
    - Interagency service coordination.
- Childhood diabetes services to meet increasing demand.
- Knowledge of Aboriginal health support workers/ programs and services.
- Sustainable Paediatrician services to meet increased demand of children with complex needs.
- Female practitioners delivering Women's health services.
- Public transport to access hub services.
- Health literacy and service availability knowledge.
- High care Aged Care Packages.
- Coordinated care with MLHD services and NGO's.

Planning for Temora Health Service includes identifying opportunities to improve health literacy, community health and outpatient services, ambulatory care services and working in closer partnership with the Primary Health Network, GPs, and Non-Government Organisations (NGO's) and cross border services. Temora Health Service has established relationships with the Whiddon Group, a residential aged care facility located adjacent to the hospital.

There are opportunities for the facility to provide services more efficiently and provide additional services closer to home for residents of the catchment. This could include reversal of some flows from WWBH and other MLHD facilities for lower acuity inpatient services, including but not limited to slow stream rehabilitation.

The use of e-Health and other technological developments such as Virtual Care and Telehealth are changing the landscape of how services are being delivered. This

aligns with both the NSW Health Future Health Report and NSW 20 Year Health Infrastructure Strategy by enabling e-Health and other technologies to improve information exchange between NSW Ambulance, GP's and local Health facilities, and improve integrated care for patients.

Temora is an identified site within the MLHD Rehabilitation Service Plan for development of RDL 3 role delineated rehabilitation services. The introduction of outpatient rehabilitation services commenced late 2016 in space beside the maternity wing in a disused former ward area. The service is provided via a networked model with WWBH. The model of care for rehabilitation services using Allied Health Assistants within a networked team is receiving positive feedback from the community. The service will be expanded to include an inpatient component to support the outpatient/outreach service.

Improved and enhanced out of hospital/outreach and outpatient models of care will be implemented as part of ED presentation/hospital avoidance strategies. An analysis of the viability of an adult HITH service is required. Outpatient service delivery requires a review to reduce patient waiting times and impact on inpatient staff that currently has responsibilities for inpatients and ED.

A District wide review is underway into palliative care services. After hours and weekend support for carers and patients in the community is an issue for many communities. Any changes for Temora will be in line with District wide recommendations. The infrastructure requirements to improve end of life care in the inpatient setting will be incorporated into infrastructure funding applications, including development of a quiet room with beverage bay for family.

Acute Mental Health/ Drug and Alcohol services are busy in Temora; however, the team believe there are generally adequate services available to meet existing demand. Access to the 24/7 Mental Health Emergency Consultation Service has been helpful.

There has been a slight increase in staffing for aged care mental health services to meet increasing demand in this area; however there has been a loss of general counselling availability through other services in the community. MLHD counselling services have a domestic violence service focus. There has been a growing demand for general counselling services and psychology services in the community. Options can be explored with the Murrumbidgee Primary Care Network to meet this demand.

Headspace and Mission Australia provide services to Temora. Monthly interagency meetings between MLHD, NSW Ambulance, NSW Police and other MHDA services are a useful platform to discuss issues.

Council identified the normalised excess consumption of alcohol, particularly in relation to sporting and other events, as one of the biggest issues in the community. It was also noted that awareness of mental health as an aspect of general health and wellbeing has increased. This has led to an increased demand for mental health services and emergency mental health services. Accessline provides these services; however, it was felt there was a lack of awareness about the service in the community and opportunities exist to promote the service more broadly. Accessline is a MLHD mental health line staffed by qualified mental health workers. Council

also indicated a desire to be more involved with other services providing prevention programs for youth.

The LHAC have identified a role to develop and maintain a health service directory to improve public awareness of services available. They are also keen to be involved in improving health literacy. In conjunction with community health services, public health services, health promotion, MPHN, and interagency meetings, there are opportunities for the LHAC to increase health literacy, and work on specific issues identified by the committee. It is a focus for the LHD and LHACs to deliver community specific health message through local media.

The LHD will support The Whiddon Group with any applications to improve support of elderly people in the community. This will assist to keep people well in their homes and provide a pathway for care from the home for community health and inpatient services through early identification of issues.

17. HEALTHY BUILT ENVIRONMENTS CONSIDERATIONS

The purpose of the Healthy Urban Development Checklist (the checklist) is to assist health professionals to provide advice on urban development policies, plans and proposals. It is intended to ensure that the advice provided is both comprehensive and consistent. It provides guidance on the identification of key health issues and relevant supporting evidence and recommendations. It suggests how positive effects can be maximised and negative health effects minimised.

The checklist is principally about helping to determine what are the health effects of the urban development policy, plan or proposal and how can it be improved to provide better health outcomes.

The proposed facility upgrade of Temora Hospital (the proposal) will enable the refurbishment of health service facilities in Temora. The proposed development will provide improved facilities whilst improving the efficiency of the health care services.

The site of the new facility has yet to be finalised, but two possible options are:

1. The current hospital will be demolished with the new facility built on that site
2. The current hospital building will be retained and repurposed, with the new hospital built on vacant land within the current hospital precinct

The proposal is consistent with the relevant provisions of the checklist as follows:

- The proposed development will provide for new hospital facilities that will be co-located with existing health and aged care facilities
- The proposed development will generate additional employment during construction as well as ongoing employment opportunities once the new hospital is operational
- Transport options are being considered following extensive community consultation
- The proposed development will complement the streetscape and heritage of Temora
- A detailed consultation process has been undertaken with relevant stakeholders to encourage stakeholder involvement in planning for the facility upgrade of Temora Hospital
- Access to healthy and nutritional food is promoted by developing a retail environment that focuses on providing healthy food options
- Suitable and affordable housing is a major consideration of the proposal. Attracting and retaining a skilled workforce relies heavily on access to short and long-term housing for rent and to buy
- The new hospital will continue to be a focal point for the local community. The proposal supports community engagement and connectivity for residents

18. IMPLEMENTATION PLAN

Key Priority Area / Strategy	Action Required	Responsibility for Coordination
Within 6 Months		
Review maternity services	Review maternity midwifery model Collaborate with General Practitioners to further develop shared care models	Cluster Manager, MLHD Manager Maternity Services with: • GP Obstetricians • GP Anaesthetists
Investigate Ambulatory Care / Outpatient / adult Hospital in the Home models of care to reduce hospital admissions and length of stay and improve efficiencies	Review data for hospitalisations for Temora catchment residents Analysis of patient numbers who would be eligible for ambulatory care / outpatient-based services / adult HiTH service if it were available Review of hospitalisations of patients with ambulatory sensitive conditions	Cluster Manager and Facility Manager working with: • Integrated care team members • Director Nursing and Midwifery • Relevant CNCs • Stream Managers • GPs
Expand capacity for undergoing minor procedures such as orthopaedics and gynaecology	Ongoing perioperative nursing support Establish support services in line with the Role Delineation for minor procedures	Cluster Manager, Medical Workforce Manager, Executive Director Medical Services with: • Relevant MLHD Staff Specialists • GP Anaesthetists • CNC Perioperative Services
Establish a Pharmacy Service to be uplifted to support RDL 3 services	Develop strategies aimed at growing the pharmacy service over time	Cluster Manager, Facility Manager, Manager Workforce Planning and District Chief Pharmacist
Develop a Workforce Plan aimed at recruitment and retention of a suitably skilled workforce to support the uplift of facility and community-based services	Develop the Workforce Plan	Cluster Manager, Facility Manager, Manager Workforce Planning with: • Relevant MLHD
Within 12-24 Months		
Investigate Ambulatory Care / Outpatient / Hospital in the Home models of care to	Analyse Workforce requirements to establish and expand an ambulatory care unit,	Cluster Manager and Facility Manager, Manager Workforce Planning, working with:

Key Priority Area / Strategy	Action Required	Responsibility for Coordination
reduce hospital admissions and length of stay	outpatient, and community based adult HiTH services and outpatient rehabilitation	• Nursing and Midwifery Workforce Manager • Manager Community Health • Director Integrated Care • Director Allied Health
Increase availability of minor procedures such as orthopaedics and gynaecology	Develop visiting surgical team model Establish surgical teams	Cluster Manager, Medical Workforce Manager, Executive Director, CNC Perioperative services with: • Director Operations • GP Proceduralists and GP Anaesthetists
Increase Pharmacy RDL to 3	Develop workforce to provide for level 3 pharmacy service Review requirements to provide for a dedicated pharmacy department	Cluster Manager, Facility Manager and District Chief Pharmacist
Ongoing		
Improve heath literacy and knowledge of service availability for community providers	Work with Health Promotion, Community Health, GPs, MPHN to promote good health messages Strengthen interagency partnerships Maintain the MLHD Council Interagency Service Directory	Facility Manager with: • Health promotion Officer • Murrumbidgee Primary Health Network • LHAC • Council
Improve integrated care opportunities and awareness of and access to MHDA services across the continuum of care	Increase interagency membership Maintain awareness of community services and integrated care opportunities Meet regularly with GPs and the MPHN Work with the Rural Adversity Mental Health Program (RAMHP) as a conduit to service availability and community needs	Facility Manager, MHDA Manager, LHAC Chair

19. EVALUATION AND REPORTING

Evaluation and monitoring of services will be ongoing. This will include:

- The Cluster Manager and Facility Manager, in consultation with MLHD, the LHAC and staff, will prepare an Annual Operational Plan to indicate the relevant service priorities for the coming year. The plan will be reviewed on a regular basis to ensure services are provided in accordance with current demand.
- Integrated care meetings between multiple health service providers will monitor on-going demand against service availability. This will include access to primary health and prevention services, services provided in the home, in acute and in residential care settings.
- Health services will be provided in accordance with latest evidence-based guidelines.
- Appropriate benchmarking of services will occur to ensure they are cost effective and efficient.
- Performance indicators, as required by MLHD will be monitored and routinely reported.
- Relevant questionnaires, surveys, interviews, etc., may be conducted to monitor and review service provision.
- External surveys may be conducted to objectively evaluate service delivery and accompanying standards; and
- Timely reviews with community input will be conducted to assess if service levels are meeting demand.

20. APPENDICES

APPENDIX 1: ROLE DELINEATION – CURRENT AND PROPOSED

Service	Current	Future	Service	Current	Future
Clinical Support Services			**Surgery**		
Anaesthesia and Recovery	3	3	Burns	2	2
Operating Suites	3	3	Cardiothoracic Surgery	NPS	NPS
Close Observation Unit	3	3	Ear, Nose & Throat	NPS	NPS
Intensive Care	NPS#	NPS	General Surgery	3	3
Nuclear Medicine	NPS	NPS	Gynaecology	NPS	2
Radiology/ Interventional Radiology	3	3	Neurosurgery	NPS	NPS
Pathology	2*	3	Ophthalmology	1	3
Pharmacy	2	3	Oral Health	2	2
Core Services			Orthopaedics	NPS	3
Emergency Med	2	3	Plastic Surgery	NPS	NPS
Medicine			Urology	NPS	2
Acute Stroke	-	NPS	Vascular Surgery	NPS	NPS
Cardiology and Interventional Cardiology	2	2			
Chronic Pain Management	NPS	3			
Clinical Genetics	NPS	NPS	**Child and Family Health Services**		
Dermatology	2	3	Child and Family Health	3	3
Drug & Alcohol	2	2	Child Protection Services	1	1
Endocrinology	NPS	3	Maternity	2	3
Gastroenterology	1	2	Neonatal	1	2
General and Acute Medicine	2	3	Paediatric Medicine	2	2
Geriatric Medicine	2	3	Surgery for Children	2	2
Haematology	NPS	NPS	Youth Health	2	2
Immunology	2	2			
Infectious Diseases	2	2	**Mental Health and Drug and Alcohol Services**		
Neurology	NPS	2	Adult MH	2	2
Oncology - Medical	1	1	Child/Adolescent MH	2	2
Oncology - Radiation	NPS	NPS	Older Adult MH	1	1
Palliative Care	2	3	Drug & Alcohol Services	2	2
Rehabilitation	3	3	**Community Based Health Services**		
Renal	NPS	NPS	Aboriginal Health	2	2
Respiratory and Sleep Medicine	NPS	3	Community Health	3	3
Rheumatology	NPS	2			
Sexual Assault	1	1			
Sexual Health	NPS	NPS			

Source: NSW Role Delineation Guideline 2019 *Ongoing discussions with NSW Health Pathology

- No planned service

APPENDIX 2: CONSULTATION PLAN

Engagement with stakeholders is a key component of effective planning. A formal Stakeholder Engagement Plan was developed to ensure that a strong collaborative approach was undertaken to work with the community and organisations within the community to explore opportunities for health, maintaining health, and providing interventions when ill-health arises is expected.

A key objective was to ensure responsibility for services/ improvements is clearly articulated to ensure that stakeholders and service partners understand the purpose for the work as well as the expectations and responsibilities for their involvement in the process.

It should be noted that extensive consultations were undertaken as part of the planning for the draft Temora Health Services Plan, October 16 Version 2.1. Engagement undertaken during this planning process was used to build on the existing information obtained during previous planning exercises.

A number of different methodologies will be enacted to optimise the information obtained to ensure the Plans meet the key objectives of the planning process.

These included but were not limited to:

1. Engagement with key stakeholders - one on one consultations
2. Group sessions
3. Virtual meetings
4. On-line Survey
5. Inviting comment on the draft CSPs
6. Endorsement of the draft CSPs

Representatives who attended the consultation sessions included local health service staff and management, LHAC members, VMOs/GPs, the Whiddon Group and Temora Shire Council. In addition, invitations were also sent to Murrumbidgee Primary Health Network and NGO's providing health and social services. For those unable to attend, additional information was gathered via phone calls and an online survey. Virtual or phone contact was made with MLHD Executive and staff members, NSW Health Pathology, HealthShare NSW, and Health Infrastructure.

The Draft Plan will be reviewed by the MLHD Board prior to key stakeholder review (four week turn around). The final draft plan will be endorsed by the MLHD Executive prior to being submitted for final endorsement to the MLHD Board.

APPENDIX 3: ABORIGINAL HEALTH IMPACT STATEMENT

This statement is a summary of the requirements within the Aboriginal Health Impact Statement Policy PD2017_004.

Murrumbidgee LHD has a higher proportion of Aboriginal people than the state with 4.1% compared to 2.5% Aboriginal population and therefore service impacts are even more pertinent. Within the District, LGAs with the highest proportions of Aboriginal people are Lake Cargelligo area 14%, Murrumbidgee Shire (10%) and Narrandera (10%) and the highest disadvantaged Aboriginal communities in MLHD were around Young, Deniliquin, Gundagai, and Griffith.

It is noted that Aboriginal people represent 5% of the hospitalisations for MLHD residents and 6% of preventable hospitalisations. Categories where Aboriginal people are “over-represented” proportionally are dialysis and mental disorders and the acute preventable hospitalisations.

The Temora Service Plan will build upon the existing initiatives and propose infrastructure upgrade to provide an updated facility to support the existing Aboriginal health programs in the district.

It is acknowledged that barriers to service access potentiate health problems for the Aboriginal population. At Murrumbidgee LHD, Aboriginal Health staff is at hub sites, including Temora, with outreach sites in surrounding communities. The staff provides support by personally visiting patients in hospital and community settings and facilitate and implement health programs within their region to act as the connection between the hospital and patients. These staff are both Aboriginal and non-Aboriginal and increase the availability and access of services at all levels, not just in the hospital setting, respecting and incorporating traditional preferences.

It has also been noted that 3% of the Aboriginal population are aged 65 years and over which will continue to be addressed as the non-Aboriginal ageing population increases and services shift to focus on appropriate delivery of aged care programs and services.

Consultation occurred with the Aboriginal Health unit, local Aboriginal Health staff and local Aboriginal community representatives as part of the consultation process in the development of this plan.

The requirements of Aboriginal clients will be informed by consultation with Aboriginal Health Unit staff and Aboriginal community members through the facility planning phase.

APPENDIX 4: FEEDBACK RECEIVED

Issue	Description	Options/Recommendations for Action
Expenditure of capital funds	Funding for mental health is a priority, not necessarily $80M for an unnecessary facility which is an extraordinary allocation of funds	Letter describing reasons for a new facility as well as explaining proposed enhancements to Mental Health services
Car Parking	No mention of car parking in CSP	Email describing planning process
Facility Design	Each room to have its own bathroom	Email describing planning process
Medical Imaging	No mention of the provision of an OPG and Lateral Ceph for the purpose of dental imaging	Section 8.2 Medical Imaging has been revised to include consideration of the provision of OPG/Lat Ceph services at Temora. This will need to be further investigated by MLHD Email to be forwarded advising of the changes
Population statistics	Executive Summary states Temora have a population of 8,784...this isn't correct...Unless you're bringing in other surrounding districts – beyond Temora shire...	Change Executive Summary to 'The estimated resident population as of June 30, 2020, was 6,274'
General Comment	The plan looks amazing & exactly what is needed for Temora. well done	Comments acknowledged and response forwarded
Transitional Aged Care Community places	Inconsistent statements - Transitional Aged Care community places has the lowest occupancy rate across MLHD, dropping to 11% during December 2021 Transitional Aged Care community places have very high occupancy at 93-99% in the past four years	
Security Systems	proper security control room with big screen so all CCTV cameras across the facility and playback in control room can be monitored. The addition of a two-way radio system can be used for communication across the hospital in between nursing and other hospital teams	Security requirements will be a key consideration in the facility planning phase of the project
Pathology Services	The plan looks at upgrading services including ultrasound and CT scanning, but pathology will not be happening On site pathology is vital to ensure the highest level of safety for our Maternity Patients in not only our Temora local community but our surrounds. With increasing theatre capacity, on call theatre teams to allow for more inductions and emergency Caesareans, onsite pathology is necessary	Pathology services will be enhanced to meet the projected increase in demand and changes to service delivery. Workforce planning will address staffing capacity and requirements to enable safe delivery of service enhancements The CSP recommends A RDL 3 pathology service is required to support the proposed uplift of several clinical services to RDL 3 particularly maternity and surgery
Ariah Park	'There is not one mention of the health needs of the Village of Ariah Park, the main Village in the Temora Shire Council Local Government Area.' We are DESPERATE for speech and OT services in Temora that can outsource to Ariah Park. The wait for these services is extremely long.	Community based services are supported in the CSP. Services for specific communities require further discussion Comments are noted, to be investigated further
Community Allied Health Services	We are DESPERATE for speech and OT services in Temora that can outsource to Ariah Park. The wait for these services is extremely long.	Comments are noted, to be investigated further
Occupational Therapy	I am also curious about the comment about service gaps with occupational therapy in the Temora MLHD (Health Service Plan, p101), and the implied proposal to increase the workload for the occupational therapy role by increasing TACP services (Health Service Plan, p10) and introducing splinting (Health Service Plan, p13). In due time will this be matched by an increase	Comments noted. Workforce planning will address staffing capacity and requirements to enable safe delivery of service enhancements

	in OT positions in the local area?	
Rehabilitation Services	Our public rehabilitation services are not great especially compared to what Calvary offer. Luckily our private practices are absolutely awesome, but this is a financial barrier to patients Temora is already a Rehabilitation Role Delineation Level 3 hospital since 2016/17. Temora Hospital is part of the MLHD Outreach Rehabilitation Service providing both inpatient and outpatient rehabilitation. Currently low complexity rehabilitation patients are managed at Temora. This service already incorporated on-site and virtual care. Medical conditions such as stroke and reconditioning are also managed at Temora The service will provide services to residents of the Berrigan LGA. I don't think so, Berrigan is south of Wagga (maybe part of the Finley plan) The service will be provided on site and with visiting staff including nursing, allied health, and rehabilitation specialists. (No, rehabilitation specialists are not involved in pulmonary or cardiac rehabilitation in MLHD and are not planning to) If there is planned redevelopment for Temora hospital that includes rehabilitation, then please make use of the recommendations we provided for Tumut Hospital redevelopment. Inclusion of - Bariatric plinth - Hoist (preferably ceiling) in a larger consult room or in gym - Group room to be attached to gym space with the ability to open/close - Garden space and landscaping with functional garden beds that can be used in therapy as well as an alternative seating area - Outdoor mobility areas (curbs, grass, uneven surfaces, ramp) Kitchenette – required for ADL assessments	A 4-bed rehabilitation pod with rehabilitation clinical support service areas is proposed in the CSP Comments noted To be included in the CSP (page 72) Document updated Document updated Comment noted Comment noted
Sexual Health Services	I'm disappointed to see no mention of any sexual health provisions	A comprehensive Sexual Health Service is available at Wagga Wagga Hospital
Sterilising Services	Any Reusable Medical Devices located in Maternity must have a risk assessment as they require HEPA filtered ventilation storage area as per AS/NZS 4187. There should be no procedures performed in Outpatient areas if reusable medical devices are used, single use items are acceptable as HEPA storage area ventilation is required.	Comments noted. To be reviewed as part of the service delivery guidelines and procedures
Outpatient Clinic Rooms	I was wanting to make sure that there will be a large room dedicated for child and family approx. at least more double the size of a consult room as when the immunizations fridge and mother, babe, pram and siblings are in all together along with the bench to have the measure board, examinations table and baby scales it can get rather cramped. Also, there will be the sit on scales and stand on scales and a stadiometer (free standing measure equipment) to also be considered.	Details regarding clinic room design will be covered in the facility design phase of the redevelopment
Emergency Department	I noted that the ED would not be separately	Comments noted. Workforce planning will

	staffed after hours in the new service. My feedback to this would be that I believe the ED should be staffed after hours as this is when the majority of the presentations occur, leaving the on-shift Midwife or RN to leave their patients on the ward and attend to ED. I believe this provides less safe and effective care to the inpatients on the general ward and maternity as their nurse/midwife is busy in the ED.	address staffing capacity and requirements to enable safe delivery of service enhancements
Operating Theatres	The Audit conducted in 2019 identified that Temora was compliant after the refurbishment in 2018 There is no visiting Gynaecological VMO service to Temora. Gynaecological procedures are performed by local GP Obstetrician/Gynaecologist There will need to be further analysis if Endoscopy procedures continue to be performed at these locations as currently, they do not meet Standards for Reprocessing of reusable medical devices Advisory 18/07. Tumut is the closest accredited facility where flexible endoscopy procedures are performed 'It is proposed that there will be 1 X operating theatre capable of undertaking a range of procedures as outlined above. As well there will be a procedure room which will enable procedures to be undertaken either by GPs or visiting surgeons that do not require a full sterile environment.' Page 80. Incorrect statement as per Australian Health Facility Guidelines.	Document revised Document revised Endoscopies will continue to be undertaken at WWBH, Young and Cootamundra and Temora. The suitability of these facilities will require further investigation but is outside the scope of this CSP. Refer Australasian Health Facility Guidelines HPU 0270 Day Procedure Unit, Revision 7.0, March 2022 for operating theatre – minor - for undertaking procedures under sedation and general anaesthetic. Both AHFGs for Day Procedure Unit and Operating Unit were consulted to inform this section of the CSP Operating Theatre and Procedure room design will be covered in the facility design phase of the planning process
Floor Plans of the proposed facility	I am unable to comment without a floor plan of the hospital	Floor plans will be available following the facility phase of the project
Consultation with Specialists	With reference to Endoscopy and Perioperative Services - I hope my feedback is considered and that our local and Wagga VMO's, who will be the ones predominately providing our surgical services, will be given more opportunity to have input into the Temora Health Service Plan.	Clinical Streams were consulted at both the LHD and local level. Ongoing discussions will occur as part of the planning for services.
Endoscopy Services (see comments in Operating Theatres above)	My first point of feedback is that Endoscopy services are a must. It is a surgical service that is forever expanding and growing. Endoscopy services are one of the most common procedures performed in district hospitals in the MLHD. They are essential to ensuring theatre lists are utilised to their full capacity Providing Endoscopy services also allow for other surgical specialities to be better utilised such as Urology. Urology is currently in the proposed plan which is also great however not providing Endoscopy service does not allow for Flexible Cystoscopies which are also in high demand. These procedures can be and are most often done under local anaesthetic requiring no anaesthetist minimising costs, patient anaesthetics, risks etc. A portable Xray machine for theatre will be highly beneficial and utilised for Urology allowing for Ureteric Stents and Ureteroscopy	Comments noted and will be further investigated as part of the ongoing planning for services at Temora Health Service

	procedures, which are in high demand and one of the most common urological procedures. It would also be used in the forever growing speciality of Orthopaedics and in General for Laparoscopic Cholecystectomies which are in high demand.	Comment noted – the inclusion of specific equipment will be determined during the facility planning phase of the redevelopment
Ophthalmology services	I can only assume it has been fully considered but question the push for Ophthalmology services due to the extremely specialised field that it is. There is no equipment at all that is used in Ophthalmology that can be shared between specialities. Eyes for example require their own speciality beds, surgeon chairs, diathermy/phaco machines, a microscope, instruments and above all, an Anaesthetist that performs Eye Blocks	Comments noted and will be further investigated as part of the ongoing planning for services at Temora Health Service
Surgical Services	Endoscopy services must be included in the build and services plan. Endoscopy is the commonest surgical procedure performed at district hospitals within the MLHD. It is therefore an essential service and cannot possibly be omitted from the new surgical services plan. The current surgical services are not "sporadic". General surgery lists are routinely scheduled every 4 weeks.	Comments noted and will be further investigated by the LHD as part of the ongoing planning for services at Temora Health Service. Comments noted and appropriate section in CSP revised to reflect comments
Operating Theatres	The build should have one fully sized operating theatre	Comments Noted. Planning has identified one fully functional Operating Theatre (60sqm) and one Operating/Procedure room (45sqm). This will accommodate a range of procedures ranging from moderate surgical procedures to HVSS/day only procedures.
Spiritual space	A chapel / spiritual space should be included in the build	Comments Noted A section of Spiritual Care has been added to the revised CSP
Aged Care	Proposal that the new Temora facility include residential aged care. Noted that facility in Temora has not been successful in funding an expansion	This is not in scope for inclusion in the CSP. Noted

APPENDIX 5: ABBREVIATIONS

ABS	Australian Bureau of Statistics
ACAT	Aged Care Assessment Team
ACI	Agency of Clinical Innovation
ACT	Australian Capital Territory
ADL	Activities of Daily Living
AIDS	Acquired Immunodeficiency Syndrome
AH	Allied Health
AHA	Allied Health Assistants
AHW	Aboriginal Health Worker
ASP	Asset Strategic Plan
ATSI	Aboriginal and Torres Strait Island
APAC	Acute Post-Acute Care
CALD	Culturally and Linguistic Diversity
CHESS	Chronic/Complex Health Care Engaged
CHOC	Community Health Outpatient Clinic
CNC	Clinical Nurse Consultant
COAG	Coalition of Australian Governments
COSOPS	Critical Operations Standing Operating Procedures
CSP	Clinical Service Plan
CT	Computerised Tomography
DOHRS	Department of Health Reporting System
ED	Emergency Department
eMR	Electronic Medical Record
EN	Enrolled Nurse
ESRG	Enhanced Service Related Group
FTE	Full time equivalent
GSAHS	Greater Southern Area Health Service
GP	General Practitioner
GVH	Goulburn Valley Health
CHSP	Commonwealth Home Support Programme
HITH	Hospital in the Home
HIV	Human Immunodeficiency Virus
HSM	Health Service Manager
ISC	Inpatient Statistics Collection
LGA	Local Government Area
LHAC	Local Health Advisory Committee
LHD	Local Health District
MAP	Murrumbidgee Action Plan
MHDA	Mental Health & Drug & Alcohol
MHECS	Mental Health Emergency Consultation Service
MLHD	Murrumbidgee Local Health District
MPHN	Murrumbidgee Primary Health Network
MPS	Multipurpose Service
NAPOOS	Non-Admitted Patient occasions of service
NGO	Non-Government Organisations
NPS `	Needle and Syringe Program
NSW	New South Wales
NSWHP	New South Wales Health Pathology

OT	Occupational Therapist
PACS/RIS	Picture Archiving and Communication and Radiology Information System
PoCT	Point of Care Testing
PPH	Potentially Preventable Hospitalisations
RDL	Role Delineation Level
RITH	Rehabilitation in the Home
RM	Registered Midwife
RN	Registered Nurse
SRG	Service-Related Group
TACP	Transitional Aged Care Packages
VMO	Visiting Medical Officer
WWBH	Wagga Wagga Base Hospital
YTD	Year to Date

APPENDIX 6: REFERENCE DOCUMENTS

NSW Government Publications

- NSW Making it Happen
- NSW Department of Planning, Innovation and Environment
- Riverina-Murray Regional Plan 2036

Health Publications and Resources

- CaSPA (Clinical Services Planning Analytics Portal)
- NSW Agency for Clinical Innovation Close Observation Units – Key Principles. https://aci.health.nsw.gov.au/__data/assets/pdf_file/0007/430837/Close-Observation-Units-Key-Principles.pdf
- NSW Health, Guide to the Role Delineation of Clinical Services, 2019
- NSW Future Health Guiding the next decade of care in NSW 2022-2032
- NSW 20 Year Health Infrastructure Strategy
- NSW eHealth Strategy 2016-2026 https://www.ehealth.nsw.gov.au/about/our-strategy
- NSW Maternity and Neonatal Service Capability Framework
- NSW Health Pathology Clinical Services Plan 2019-2025
- Health Statistics NSW: http://www.healthstats.nsw.gov.au
- MLHD Clinical Services Framework 2021-2026 Draft v1.3
- Healthy Built Environment Checklist
- Australian Bureau of Statistics
- Australasian Health Facility Guidelines
- Murrumbidgee Primary Health Network Strategic Plan 2019-2022

Murrumbidgee Local Health District Publications

- MLHD Strategic Plan Exceptional Rural Healthcare 2021-2026
- MLHD Service Agreement
- Murrumbidgee Local Health District Chief Executive Goals
- MLHD Rehabilitation Clinical Service Plan – currently under review
- MLHD Renal Clinical Services Plan 2 currently under review 013-2017
- MLHD Surgical Services Plan – currently under review
- MLHD Mental Health and Drug and Alcohol Clinical Services Plan - currently under review
- MLHD Aged Care Clinical Services Plan 2 - currently under review
- MLHD Asset Strategic Plan 2021-22
- Wagga Wagga Health Service Aboriginal Health Service Model of Care July 2020 Revision 2

Local Government Publications

- The Temora Shire 2030 Community Strategic Plan

APPENDIX 7: EMERGENCY DEPARTMENT TRIAGE CATEGORIES DESCRIPTION

Triage 1:	People in this group are critically ill and require immediate attention. Most would arrive by Ambulance
Triage 2:	People in this group suffer from a critical illness or are in very severe pain. People with serious chest pains, difficulty in breathing and severe fractures are included in this group.
Triage 3:	People in this group suffer from severe illness, bleed heavily from cuts, have major fractures, or be dehydrated.
Triage 4:	People in this group have less severe symptoms or injuries, such as a foreign body in the eye, sprained ankle, migraine or earache.
Triage 5:	People in this group have minor illnesses or symptoms that may have been present for more than a week, such as rashes or minor aches and pains.

Source: Eddison