OFFICIAL: Sensitive – NSW Government

Northern Sydney Local Health District

High Volume Surgical Hub (HVSH)

Staff Information

June 2026

High-volume surgical hub vs general theatre lists

Focused case-mix

- Designed for high-volume, low-complexity, predictable planned procedures vs mixed complexity and urgency.

Protected elective capacity

- Ring-fenced theatres, beds and workforce, insulated from emergency and acute pressures.

Standardised operating model

- End-to-end standardisation (pre-admission, anaesthesia, theatre set-up, turnaround, discharge) vs bespoke specialty-driven processes.

Dedicated specialist teams

- Stable teams repeatedly delivering the same procedures, driving efficiency, quality and reliability.

Policy- and evidence-based model

- HVSSS principles are embedded in NSW policy and ACI guidance and draw directly on evidence from UK high-volume cataract hubs.

Key Components of a High-Volume Surgical Hub (HVSH) Model of Care

1. Purpose and Scope

- Clear definition of what the HVSH is designed to deliver (e.g., high-volume, low-complexity, short-stay surgery).
- List of included specialties/procedure types (and exclusions).

2. Patient Eligibility & Referral Pathways

- HVSH inclusion/exclusion criteria.
- Standardised referral process (statewide or LHD-wide).
- Pre-operative criteria (fitness for short-stay).
- Escalation pathways for unsuitable patients.

3. Pre-Admission & Pre-Operative Assessment

- Telehealth options for statewide access.
- Standardised risk assessment, investigations, and optimisation protocols.
- Defined anaesthetic assessment pathways.

4. Surgical Workflow & Peri-operative Pathways

- Standardised clinical pathways by procedure type.
- Date-of-surgery admission model (DOSA).
- Evidence-based ERAS/short-stay protocols/CLD.
- Defined turnover processes to enable high throughput.

5. Workforce Model

- Workforce configuration (ring-fenced, external, hybrid).
- Roles/responsibilities (surgeons, anaesthetists, peri-op team, ward).
- Staffing ratios for theatre, PACU, and short-stay care.
- Training, competency, and capability requirements.

6. Theatre & Bed Configuration

- Protected HVSH theatres and recovery spaces.
- Short-stay ward/same-day unit requirements (beds, hours of operation).
- Equipment, instruments, and standardised sets.
- Surge planning and weekend/extended hours model (if applicable).

7. Discharge Planning & Post-Operative Care

- Same-day/24-hour discharge criteria.
- Standardised discharge instructions and patient education.
- Post-op follow-up pathways (virtual, phone, or in-person).
- Complication, readmission, and escalation protocols.

8. Governance & Clinical Safety Framework

- Clinical governance structure (local + statewide).
- Oversight of quality, performance, safety, and risk.
- Incident, escalation, and clinical handover processes.
- Credentialing requirements for internal/visiting surgeons.

9. Operating Model & Scheduling Rules

- List allocation rules (internal vs external surgeons).
- Protected scheduling and cancellation governance.
- Booking and waitlist management model (local + statewide).
- KPI-driven scheduling (e.g., cases per list, turnover time).

10. Patient Experience & Communication

- Patient-centred information pathways (before, during, after surgery).
- Statewide navigation for out-of-area patients.
- Cultural and accessibility considerations.

11. Data, KPIs & Performance Monitoring

- Agreed KPIs (throughput, cancellations, LOS, theatre efficiency, outcomes).
- Real-time and monthly performance reporting.
- Outcome and complication tracking.
- Regular monitoring and hub optimisation cycles.
- Policy requirements

12. Integration with System Partners

- Alignment with local hospitals (for escalation, complications).
- Statewide coordination for referrals and demand distribution.
- Partnerships with primary care, community services, and rehabilitation

Governance

Purpose

- Provide strategic oversight, governance and direction for the establishment and operation of the HVSH at NBH.
- Support safe, efficient and sustainable surgical services through implementation guidance, performance monitoring and timely decision-making.
- Ensure equitable access and compliance with NSW Health policies and clinical governance frameworks.

Governance/Steering Committee Responsibilities

Strategic Direction & Alignment
- Provide strategic oversight for HVSH establishment and operations
- Guide and endorse model of care, service scope, and implementation
- Ensure alignment with NSW Health priorities and policies

Oversight of Delivery
- Oversee HVSH Working Group and endorse key deliverables
- Support timely issue resolution and implementation milestones

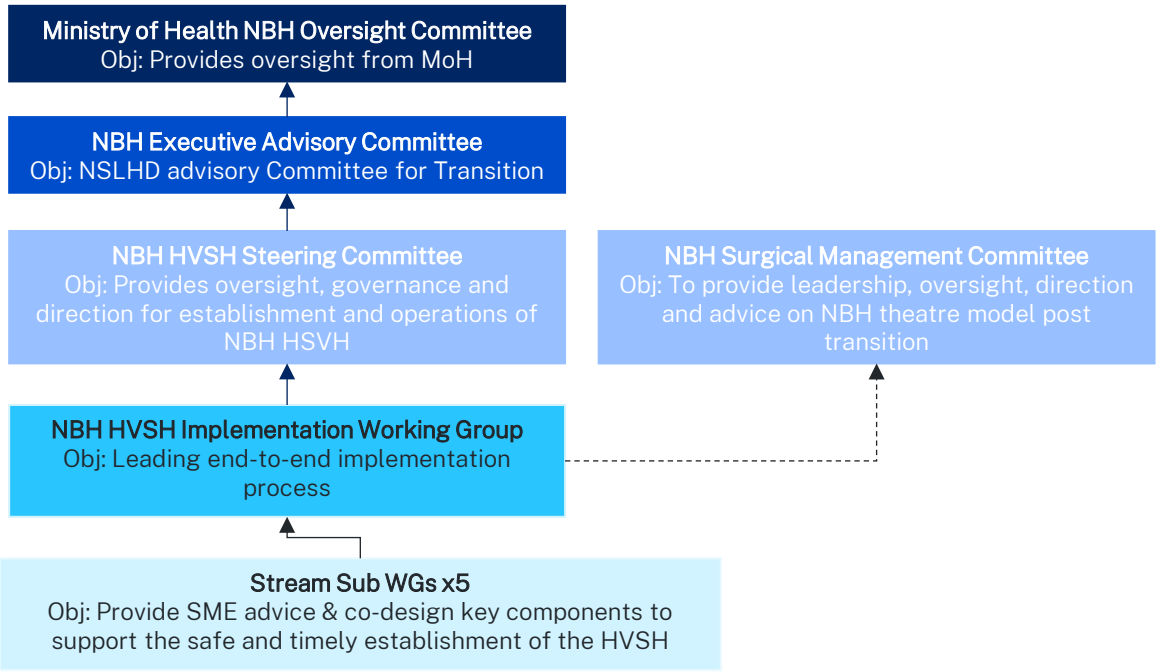
Governance, Quality & Safety
- Maintain clinical governance, quality, and patient safety oversight
- Promote continuous improvement informed by data and outcomes

Risk, Access & Stakeholder Engagement
- Identify and mitigate key risks and issues
- Oversee access and equity, including referral pathways
- Support engagement with Ministry of Health and key stakeholders

Performance & Accountability
- Ensure accountability for performance, delivery, and outcomes
- Monitor activity, performance, and implementation progress
- Oversee resource utilisation and sustainability

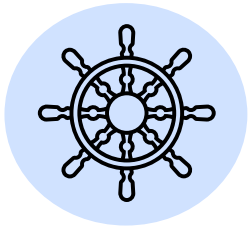
Membership

- Senior Clinical, Operational and Executive Membership
- Facility, LHD, Ministry Representatives



Clinical Governance

HVSH's clinical governance will ensure that increased elective surgery capacity is delivered with strong accountability, consistent standards, safe escalation, and ongoing monitoring of quality and patient outcomes.

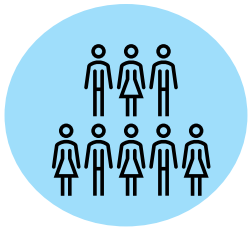


Clear accountability and leadership

- defined governance across Ministry, LHD, facility and implementation structures
- executive and clinical oversight of safety, quality and service delivery

Risk incident and escalation pathways

- active identification of cross-site risks
- clear escalation pathways
- incident reporting
- use of open disclosure where a patient safety incident occurs



Workforce governance

- credentialing
- scope of practice
- competency
- workload and fatigue oversight to support safe delivery across sites

Value based care

- routine monitoring of:
  - throughput
  - cancellations
  - outcomes
  - complications
  - patient experience
  - regular review through governance committees and morbidity and mortality processes

Partnering with patients and consumers

- clear communication
- informed consent
- health literacy
- patient-centred pathways across referral, treatment and follow-up

Implementation Approach

A **three-phased implementation** approach allows HVSH to be introduced **safely, tested and refined** in and operational setting, and scaled only once **capability and capacity are confirmed**.

Beginning with a **low-risk** proof of concept, the model is progressively strengthened through **workforce and system validation** before transitioning to a **dedicated, ring-fenced service** that delivers **sustainable, efficient** and predictable surgical care.

Phase 1: Proof of Concept
(Commencing July 2026)

- Activity embedded within existing services - No ring-fenced theatres or beds.
- Focus on low-complexity, day-only cases
- Phase 1 to test workflows and staffing during the winter period.
- Commencing with 2 specialty areas (ENT & Urology)
- Patients will be from within NSLHD & CCLHD.
- Outsourcing for these specialities and procedures for NSLHD patients will cease.

Phase 2: Capacity Validation
(Commencing late Sept 2026)

- A controlled transition phase
- Includes all remaining specialities
- Phase 2 allows for workforce recruitment, system readiness and bed capacity assessment
- Expansion of activity or referrals occurs only once capacity is demonstrated
- Moderate uplift in daily activity and will progressively meet expected annual target
- Outsourcing for these specialities and procedures for NSLHD patients will cease.

Phase 3: Dedicated HVSH
(Commencing early 2027)

- Introduction of a dedicated, ring-fenced Hub
- Protected OT Capacity
- Appropriately resourced perioperative teams
- Predictable volumes
- Enhanced statewide surgical access

Sub Working Groups

Patient Flow & Pathways (LHD–LHD)

Objectives:

- Review and refine current patient selection and acceptance criteria
- Define clear inclusion and exclusion criteria (Surgical & Ax)
- Establish standardised referral criteria across all LHDs
- Confirm consistent preoperative diagnostic requirements. (aligned with Pre/Post SWG)
- Implement governance measures including approved procedure lists and ongoing review/monitoring

Membership

- Heidi Barclay
- Ange Hardy
- Danni Birchall
- Holly Teu
- Dr Anne Greer
- Robyn Moore/Maddi Watson
- Lisa McEvoy
- Liz Jacobs

Patient Selection & Clinical Acceptance Criteria

Objectives

- Review and refine the current pathway/flow, identifying gaps, shortfalls, and missing elements
- Map the end-to-end patient journey (referral → procedure → follow-up), including central intake/single coordination point
- Define clear triage, scheduling processes, and roles/ownership at each stage
- Plan for discharge and clinical escalation pathways
- Identify and address system bottlenecks, leading to finalisation of the pathway

Membership

- Heidi Barclay
- Ange Hardy
- Danni Birchall
- Dr Stuart Pincott
- Surgical Specialty Delegates
- Dr Anne Greer

Pre & Post Operative & Follow-up Care

Objectives:

- Align processes and space requirements by assessing current vs required state
- Standardise pre-operative optimisation (incl PAC, diagnostics, medication management etc)
- Define recovery and escalation pathways
- Establish a consistent follow-up care model (modality, timeframes, and location)
- Set clear cross-LHD expectations to ensure coordination, and accountability

Membership

- Heidi Barclay
- Ange Hardy
- Danni Birchall
- Robyn Moore/Maddi Watson
- Holly Teu
- Lisa McEvoy
- Sarah Coleman

Procedural Delivery & Site Readiness

Objectives

- Confirm infrastructure, equipment, and consumables requirements
- Ensure suite design supports efficient workflows, patient flow, and throughput
- Develop the operational model (session times, scheduling, and capacity targets)
- Ensure compliance with infection control, safety, and regulatory standards
- Plan for contingencies, including equipment failure and surge capacity management

Membership

- Heidi Barclay
- Ange Hardy
- Danni Birchall
- Lachlan Munro
- Dr Anne Greer
- Emma Page
- Wilson Biason
- OT Specialty NUMS

Workforce & Capability

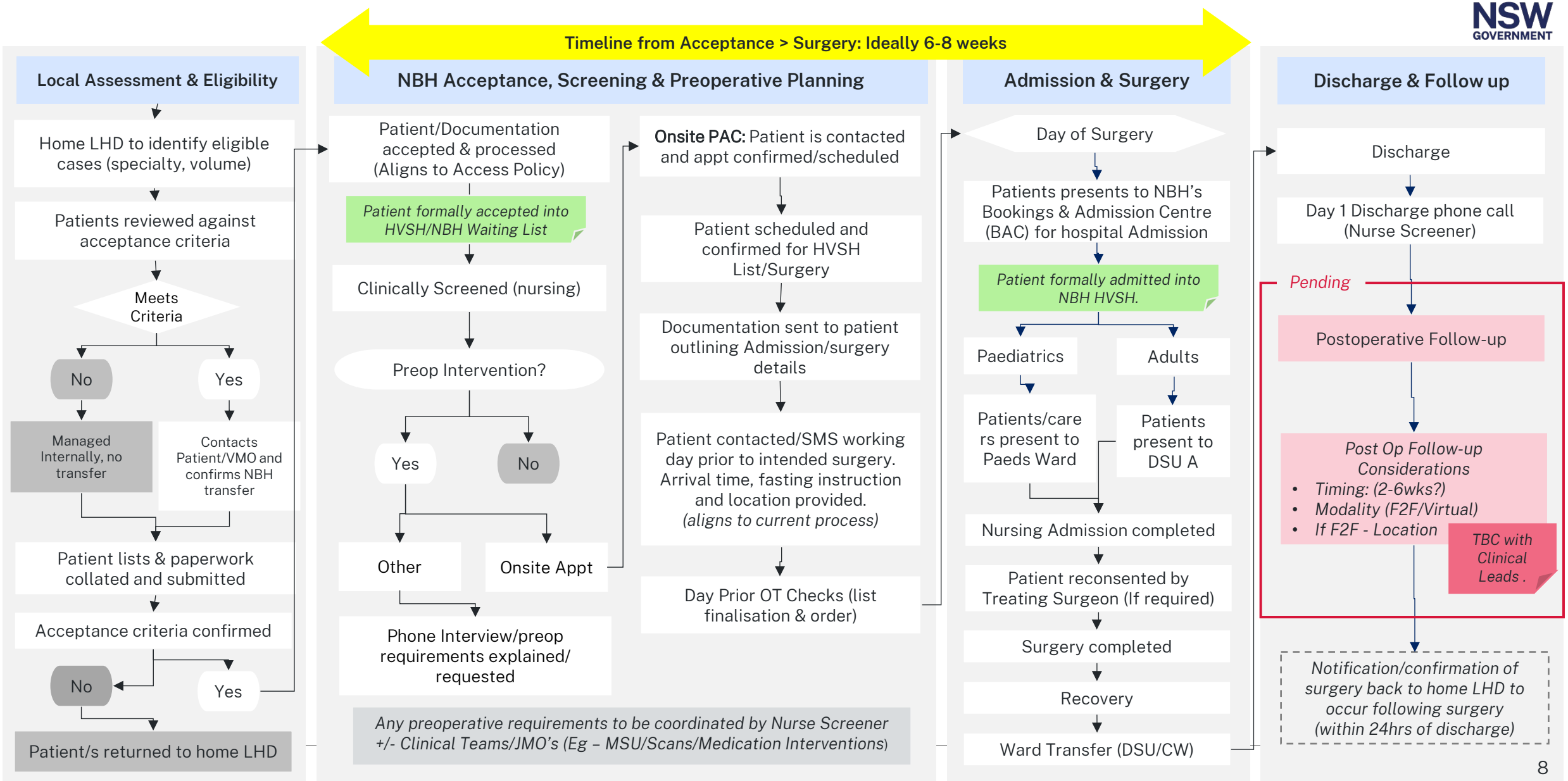
Objectives

- Identify workforce gaps & shortfalls across all disciplines
- Early identification of critical roles required for service delivery and scaling
- Recruitment and onboarding strategy for specialised and hard-to-fill positions
- Monitor workforce sustainability (fatigue, workload, rostering, retention risks)
- Plan for cross-LHD workforce models to ensure flexibility, coverage, surge capacity)

Membership

- Bronwyn Nolan
- Danni Birchall
- Dr Stuart Pincott
- DMS
- DON
- Med Admin
- Specialty Group Delegates

HVSH- Patient Pathways:



HVSH- Acceptance Criteria

Referral Requirements

1. Patient is currently listed on their home LHDs elective surgery waitlist.
2. Home LHD has reviewed the patient and confirmed the following:
    - The patient meets the clinical criteria for acceptance by the receiving facility.
    - The patient understands and agrees to undergo surgery with alt surgeon/facility.
    - The patient is willing and able to travel to and from the receiving facility for:
        - Pre-operative appointments, Surgery, Hospital stay (if required) & Post-op requirements

Note: All travel arrangements and associated planning must be completed by the home service prior to referral. Any transport requirements remain the responsibility of the home LHD.

Responsibilities for Patient Communication & Handover

1. The home LHD retains responsibility for all patient communication until NBH formally accepts the patient.
2. Once accepted, the NBH will contact the patient directly to provide:
    - Confirmation of acceptance
    - Pre-operative instructions
    - Scheduling details
    - Relevant hospital information
3. The receiving facility assumes responsibility for all routine booking, preparation, peri-operative care, and immediate post-operative processes once the patient has been accepted.

Clinical Criteria for Acceptance (Generic /Example)

Patients must meet all general clinical criteria below:

- Referring clinician agrees to the patient being managed through the HVSH model.
- There has been no significant change in the patient's health status since being placed on the elective waitlist.
- The patient is listed for a procedure and specialty supported by the receiving facility/model.
- Baseline suitability criteria (example thresholds):
    - **Age:** e.g., < 80 years
    - **ASA status:** typically ASA 1–3
    - **BMI:** e.g., < 35
    - **Planned discharge:** Day-only (DO), Early Discharge Overnight (EDO/23 hr), or short stay per agreed criteria
    - **Length of stay:** Day-only or short-stay procedures only; any exceptions must be pre-approved
    - **Discharge plan:** Appropriate home supports or assistance schemes identified where required

Note: Staged or multi-step procedures (e.g., biopsy followed by further definitive surgery) are generally not accepted unless pre-agreed.

Example Only

Q&A - Overview and Strategic Context

What is happening?

Northern Beaches Hospital will commence as a **high-volume surgical hub** from **1 July 2026**, providing additional elective surgery capacity for suitable public patients.

Why has the HVSH been established at Northern Beaches Hospital?

The model forms part of a statewide initiative supported by Government to:

- Increase surgical throughput
- Reduce overdue elective surgery
- Deliver ringfenced, high-volume same-day services

What is the benefit of this model?

The HVSH model has multiple benefits:

- Protects planned surgery from emergency disruption
- Increases efficiency through standardised high-volume lists
- Improves patient access and waiting times
- Provides a scalable approach to managing demand

Is this a pilot or a long-term model?

The HVSH is an initial implementation, designed to test and refine the model. It is expected that similar hubs will be established across the state over time.

Q&A - Overview and Strategic Context

What is happening in Phase 1 and when will the HVSH go live?

- Phase 1 of the High-Volume Surgical Hub (HVSH) includes design and planning (May 2026), readiness (June 2026), and go-live and stabilisation (July to September 2026).
- The service will go live in the week commencing 1 July 2026, with initial cases commencing shortly thereafter.
- Preparation activities include establishing governance and working groups, confirming referral pathways, developing the operational framework, and progressing recruitment, with clinical areas (theatres, wards, PACU) prepared ahead of commencement.

How will Phase 1 operate clinically during the initial months?

During Phase 1, the focus will be on safe commencement and stabilisation of services, including:

- Treating initial HVSH patients and completing workforce onboarding
- Embedding clinical pathways and screening processes
- Monitoring patient flow, cancellations, and throughput
- Identifying and addressing early operational issues

Performance will be regularly monitored, with fortnightly and monthly reporting aligned to existing governance structures, and rapid improvements implemented where required.

Q&A - Model of Care and Scope

What surgical specialties are included?

- In the initial phase, the hub will deliver surgery in ENT Surgery and Urology.
- Once fully scaled, the hub will be expanded to include ENT Surgery, General Surgery, Ophthalmology, Orthopaedic Surgery & Urology (NSLHD priority)

What is the Model of Care?

- Predominantly **date-only surgery**
- Short stay (up to one night) only, during the initial phase
- No complex or high-acuity inpatient pathways in scope at commencement

How are patients assessed as suitable for HVSH?

Patients are selected using standardised criteria, including:

- Procedure type
- Clinical indications
- Comorbidity profile
- Suitability for same-day care

When should LHDs factor NBH into list planning?

- LHDs should factor NBH capacity into planning from early May 2026, noting:
- Elective surgery lists are typically booked anywhere between 2–6 weeks in advance
- Formal confirmation of go-live and referral pathways will be provided by early June 2026

Q&A - Referral, Access and Patient Pathways

How are patients referred?

- Patients who are already waiting for a planned procedure and are overdue can contact their home hospital and advise they are interested in having surgery at the NBH high volume surgical hub.
- Treating teams and facilities/LHD's will also be identifying suitable patients and discuss NBH as an option.
- Referral pathways and contact details will be issued separately

How will patients be informed?

- A joint NSLHD and Ministry of Health media statement will be issued prior to go-live.
- Patients will be advised to lodge interest via their current listing hospital.

How are patients travelling long distances managed in a same-day model?

Scheduling will account for travel factors. Patients travelling longer distances will generally be scheduled earlier in the day.

Patients local to the facility may be scheduled later. This supports safe discharge planning.

Do patients need to be informed they may be treated by another surgeon or at another hospital?

Yes. Under the NSW Planned Surgery Access Policy, patients must be informed at the time they are placed on the waitlist that they may not be treated by the originally nominated surgeon and that their procedure may occur at a different facility. This is a standard part of the NSW consent process.

Q&A - Clinical Information, Consent and Perioperative Care

Are consents completed in another LHD valid?

Yes. Consent forms completed using NSW-approved documentation are valid across public facilities. However, we will reconsent at NBH.

Will sufficient clinical information be provided?

Yes. Complete referral information is a requirement of acceptance into the HVSH pathway. Minimum data requirements apply and must be met before listing.

What happens if the referral information is incomplete?

The referral will be returned or clarified prior to scheduling. Incomplete cases will not proceed to theatre.

How will this work across LHDs?

For NSLHD patients, information is already available via eMR. For cross-LHD pathways, this will improve further with SDPR implementation.

Can I be confident that the procedure listed for the patient is the right procedure?

Yes. The model relies on established clinical standards, credentialled practitioners and agreed eligibility criteria. If additional information is required, this can be requested prior to surgery.

Q&A - Patient Experience and Perioperative Care

Who is responsible for post-operative follow-up?

Follow-up will occur with the referring clinician or service in line with the agreed model of care. Clear responsibility for follow-up will be confirmed prior to surgery, and all patients will receive defined follow-up arrangements at discharge. If the patient was originally seen in an outpatient clinic then the follow up will be completed in that clinic and if it was a private referral, the follow up is completed in the referring surgeon's private rooms.

What support is provided immediately post discharge?

All patients will receive:

- Clear discharge instructions
- Follow-up arrangements
- Contact details for escalation
- a next-day follow-up call from a clinician.

How will pathology and results be managed?

Results will be available through standard systems (eMR currently, and SDPR in future). Communication processes will support continuity of care.

Q&A - Workforce & Participation

What staffing is being recruited to support the HVSH?

Key HVSH positions have already been identified as critical to the implementation of the HVSH. A clinical nurse screener, administration officer and HVSH Coordinator positions are progressing through internal recruitment processes

- The **HVSH Coordinator** will provide end to end operational leadership across patient flow, theatre scheduling, and inter district engagement, ensuring optimal utilisation of capacity, proactive management of operational risks, and compliance with policy requirements.
- The **HVSH Clinical Nurse Screener** will lead preadmission screening and readiness assessment, confirming patient suitability for short stay pathways, coordinating outstanding investigations, and standardising perioperative processes to reduce variability across referral sources.
- The **administration officer** will provide administrative support to clinical and operational teams, maintaining accurate records, responding to enquiries, and assisting with scheduling and documentation to ensure smooth day-to-day service delivery. They will also support patient journey for any patients returning for post operative care in outpatients.

What happens if local surgeons are unable to participate due to existing workload?

The preference is for local clinicians to participate. However, if capacity is limited:

- Additional surgeons may be mobilised from across the LHD or broader system
- Locum or contracted clinicians may be engaged to deliver the service

This ensures patients receive care within recommended timeframes.

Q&A - Workforce & Participation

Will HVSH reduce my current theatre access or sessions?

No. HVSH is a separately funded service and does not reduce existing theatre allocations. It is not a redistribution of current activity.

Will I have an opportunity to review patients before the operating day?

Yes. Operating lists and patient information will be provided approximately 7–10 days in advance. This allows time to:

- Review clinical details
- Request further information
- Identify any issues prior to day of surgery

How are workforce and fatigue risks managed?

- Disclosure of total workload across facilities
- Compliance with safe working guidelines (AMA).
- Additional safeguards include limits on extra sessions

Q&A - Safety, Governance & Medico-Legal

Who is clinically responsible for the patient during the HVSH episode of care?

The operating clinician at NBH is responsible for the patient during the surgical episode of care. Following discharge, ongoing care and follow-up revert to the referring clinician or designated service in line with the agreed model of care.

Can I decline a patient allocated to my HVSH list?

Yes. Clinicians can request additional information or decline a patient where there are clinical concerns regarding suitability. This will be managed through agreed processes prior to the day of surgery.

What happens if a patient is assessed as unsuitable on the day of surgery?

While rare, this can happen with any patient requiring surgery. While there are a number of processes in place to support appropriate patient selection and readiness for surgery, there may be some patients who present not well on the day. Patients who are not clinically suitable for same-day surgery will be managed in line with escalation protocols, including return to the home LHD where appropriate. This reinforces safe patient selection and clinical decision-making.

What happens if a patient experiences complications after discharge?

Patients will be provided with clear escalation instructions and contact points. Clinical pathways are in place to ensure patients can be reviewed promptly at their home LHD or presenting facility if required.

Q&A - Safety, Governance & Medico-Legal

Are procedures performed under the HVSH covered by the Treasury Managed Fund (TMF)?

Yes. Where clinicians are providing care to public patients in a public facility under contract with NSW Health, TMF coverage applies in the same way as it does for standard planned and emergency activity. This applies regardless of where the patient was originally referred from.

Do I need to notify my private insurer for HVSH cases?

No. For activity undertaken under NSW Health arrangements where patients remain 'public patients', clinicians are acting as agents of the public facility and are covered by TMF. These cases are not managed through private indemnity arrangements.

Does TMF coverage change if the patient was referred from another LHD or private rooms?

No. TMF coverage applies to the episode of care delivered in the public facility, not the origin of referral. We will re-consent the patient to provide additional assurance in line with Medicare Principles.

How are medico-legal risks managed?

- Obtaining informed consent at the host site, with consent explicitly naming the VMO and facility and covering all relevant risks.
- Appropriate credentialling and privileging and formal agreements that clearly define accountability and liability arrangements that clearly defines liability arrangements.

Q&A - Safety, Governance & Medico-Legal

How are HCCC complaints managed for HVSH cases?

- Complaints relating to care delivered under the HVSH model are managed at the facility level. When a clinician is acting as part of the public system, the complaint is directed to the facility. If a clinician receives a complaint directly, follow the TMF processes and forward the complaint to the Patient Representative to coordinate a response. The response is coordinated centrally by the facility, with input from the clinician and relevant stakeholders, and is issued under the signature of the General Manager or Chief Executive.

How will we ensure the safety of the patients given they are transferring care to another surgeon?

- Patient safety remains the highest priority for the HUB. The implementation team is working closely with our surgeons and multidisciplinary clinical teams to ensure all processes are designed with safety at the forefront.
- Robust and clearly defined acceptance criteria are being developed in collaboration with key clinical and operational stakeholders. This will ensure that only patients who are clinically appropriate are accepted into the HVSH model of care.
- Comprehensive preoperative requirements are being established, outlining the clinical information, assessments, and optimisation steps required prior to final acceptance. This will support consistency in decision-making and ensure patients are fully prepared before surgery.
- Ongoing governance, communication, and clinical oversight will be embedded throughout the process to maintain continuity of care and minimise risk when care is transferred between surgeons

Q&A - Safety, Governance & Medico-Legal

What controls are in place to prevent post-operative failures?

- Using defined histopathology and results pathways with results copied to referring clinicians and GPs.
- A 48-hour post-discharge patient follow-up process and clear allocation of responsibility for ongoing care further reduce the risk of failures.

How are risks being managed to ensure safe implementation?

Implementation risks include workforce availability, seasonal demand pressures, equipment readiness, and competing system priorities. These are being actively managed through:

- Phased implementation and controlled activity ramp-up
- Early recruitment and procurement processes
- Clear escalation pathways and performance monitoring
- Clinician engagement and targeted communications
- Strong governance and coordination across LHDs and the Ministry

Progression to future phases will be gated by safety, workforce sustainability and performance outcomes.

Q&A - System Impact and Policy

What does this mean for patients currently on the NBH waiting list?

Nothing changes. Patients listed at NBH will continue to be managed and treated in line with their clinically recommended timeframes.

Does this change the waiting list rules or urgency categories?

No. Existing NSW Health waiting list policies, clinical urgency categories and prioritisation rules continue to apply. Patients will continue to be treated in order of clinical urgency and based on time on the waitlist, consistent with current Planned Surgery Access policy requirements. The HVSH operates within the existing Planned Surgery Access framework and is designed to improve access, not change policy.

Will outsourcing continue to be available in NSLHD post go-live?

The intent is to close behind outsourcing for overdue NSLHD cases appropriate to be completed in the HVSH in line with each speciality 'go-live'. In phase 1, this means for ENT and urology procedures overdue in NSLHD that are appropriate to the HVSH will no longer have access to outsourcing at private facilities.

Q&A - System Impact and Policy

How does the HVSH approach to transferring patients between doctors align with the NSW Health Surgical Access Policy PD2025_036?

The HVSH model reflects NSW Health policy by supporting both patient allocation by the hospital and transfer of care between clinicians where needed to ensure timely treatment. Under the policy:

- Public patients are allocated to clinicians by the hospital, not individual doctors
- If demand exceeds a doctor's available theatre capacity, clinicians must either take on additional sessions or collaborate with the hospital to enable another appropriately credentialled doctor to perform the procedure

The HVSH embeds this through:

- Pooled waitlists and shared care models
- Allocation of patients to available, appropriately credentialled surgeons within the service
- Formal clinical handover processes to ensure safe continuity of care

Patients are informed of this approach so they understand that their procedure may be performed by another doctor within the team, or at another public hospital if required, to ensure they receive care within clinically recommended timeframes. This approach is consistent with policy expectations and is a key enabler of improving access to surgery while maintaining safe, high-quality care.

Q&A - Implementation and Expectations

What is expected of clinical teams during implementation?

Clinical teams will play a key role in:

- Supporting patient identification and triage in line with agreed criteria
- Participating in specialty consultation and pathway development
- Embedding day-only and short-stay models of care
- Supporting clinical readiness across perioperative services

Ongoing clinician engagement will also inform continuous refinement of pathways and service delivery throughout Phase 1.

What infrastructure and equipment investment supports the HVSH?

Two key capital investments are supporting delivery:

- specialist equipment procurement (including ENT and Ophthalmology)
- upgrade and fit-out of Theatre 15

These investments are being delivered in parallel to support timely activation and progressive scaling of surgical activity.

Q&A - Implementation and Expectations

What will this investment enable for clinical services?

The capital investment will support:

- Expansion of surgical capability in targeted specialties
- Availability of specialist equipment aligned to HVSH procedures
- Progressive scaling of surgical volumes
- Improved alignment between infrastructure, workforce, and clinical pathways

A key focus is ensuring equipment procurement and theatre commissioning are aligned to enable safe, efficient, and timely service expansion.

How are delivery and clinical readiness being coordinated?

Delivery is being coordinated through parallel workstreams across NSLHD and Health Infrastructure, with:

- Early engagement of clinical, operational, and procurement leads
- Alignment of equipment delivery with theatre commissioning timelines
- Ongoing stakeholder coordination and governance oversight

This coordinated approach is designed to support operational readiness, minimise delays, and maintain implementation momentum.

Q&A - Future State & Growth

How will surgical activity and throughput increase over time?

Surgical activity will increase incrementally during Phase 1, informed by capacity, workforce availability, and operational performance.

Further growth will occur as:

- Capacity is validated in Phase 2
- Additional LHDs and referral pathways are incorporated
- Opportunities such as additional operating sessions (e.g. Saturdays) are explored

Throughput modelling will continue to be refined based on demand, system capacity, and performance data.

What happens in phase 2 and beyond?

As the model matures, additional specialties, increased volumes and expanded referral pathways will be introduced in a controlled and phased manner, subject to safety, workforce and capacity.

Contact

If you have any questions or suggestions, please contact NSLHD-NBH-HVSH@health.nsw.gov.au