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INQUIRY INTO THE MANAGEMENT OF HEALTH CARE DELIVERY IN NSW

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Inquiry Into the Management of Health Care Delivery in NSW

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Introduction:

I write on behalf of my community in providing this submission to Public Accounts Committee Inquiry into the Management of Health Care Delivery in NSW.

On a daily basis I am contacted by Blue Mountains residents who hold concerns about the capacity of our health system to respond to their health needs. Whether it be surgery waiting times, capacity of our hospital emergency departments or the mental health system, my constituents highlight a health system which is struggling to find the capacity to respond with timely and appropriate care and treatment.

It is likely that these problems will only worsen at both of my local hospitals with the increasing population in this region. With the ageing of the population and the effects of socio-economic disadvantage, presentations and health issues are becoming increasingly complex, frequently accompanied by increased acuity.

The health system is reliant on the good will of its workforce. I take this opportunity to acknowledge the professional and dedicated healthcare workforce which staff our hospitals and community health facilities. Staff must be acknowledged and supported and their perspective valued to ensure a system which is sustainable and one that is willing to reflect on what it does well but also where it can do better.

There is no doubt that we have a world-class public health system. Nevertheless without adequate funding and resourcing the health system will be ill-prepared to meet the challenges of coming decades, especially with regards to the ageing of the population and with this growing chronic and complex disease.

It is worth noting the continuing growth in mental disorders and distress facing many within our community and the challenges facing the health system in providing a timely, comprehensive and compassionate response.

This submission is divided into two parts. Part one deals with the issues affecting the capacity of the broader health service system to address the needs of the Blue Mountains community and part two addresses the delivery of mental health services and related issues in my area. I also aim to look at alternative ways to address these issues, given current funding constraints.

I wish to acknowledge my constituents who have come forward and raised their concerns and complaints with me. This no easy task but the system cannot learn unless it is made aware of its gaps and shortcomings. I also honour the doctors, nurses, allied health and support staff who provide on-going care under challenging circumstances. I also wish to acknowledge Brett Holmes, Rita Martin and Jon Farry from the NSW Nurses Association for their leadership.

I also wish to take this opportunity to acknowledge the hard work and determination of the NSW Shadow Ministers for Health and Mental Health who have been advocates for patients across NSW in holding the NSW Government to account.

TRISH DOYLE MP

Member for Blue Mountains

The Nepean-Blue Mountains Local Health District (NBM LHD):

Blue Mountains District ANZAC Memorial Hospital:

Blue Mountains District ANZAC Memorial Hospital (BMDAMH) is located between Leura and Katoomba. It is an acute hospital with inpatient and outpatient services and hists 97 beds. The hospital employs 584 staff are local Blue Mountains residents.

Facilities include an emergency department, child and maternity services, medical, rehabilitation, mental health, cardiac clinic, outpatients and day surgery.

Springwood Hospital:

Located in the middle of the Blue Mountains, half-way between Blue Mountains and Nepean Hospitals, Springwood Hospital has 30 beds. In addition to in-patient services, Springwood Hospital provides day surgery.

Nepean Hospital:

Nepean Teaching Hospital is a 520-bed teaching hospital. Nepean Hospital is located at the base of the Blue Mountains in Penrith, New South Wales, Australia. Nepean Emergency Department treats over 54,000 patients annually.

Each year, Nepean Hospital treats more than 51,000 people in its ED, has approximately 51,000 patients staying at least one night in hospital, performs more than 10,000 emergency and planned surgical procedures and provides 600,000 outpatient services. This is a mammoth job, ensuring each and every patient deserves safe and appropriate care and treatment. [1]

Community Health Facilities:

The Blue Mountains community is serviced by three community health centres – located in Katoomba, Lawson and Springwood. Services provided by these facilities include chronic and complex care and home nursing, baby and early childhood services, drug and alcohol services, counselling and other allied health services and community mental health.

Non-Government Organisations:

In addition there are a number of Health-funded non-government organisations (NGOs) operating in the Blue Mountains including Blue Mountains Women's Health and Resource Centre, Blue Mountains Palliative Support Service and GREAT Community Transport that provide health services within a community setting utilising a social model of health. The NGOs, whilst often small, complement those services provided by the NBM LHD.

[1] https://en.wikipedia.org/wiki/Nepean_Hospital

PART ONE: Health Needs of Blue Mountains residents:

a) Emergency Department Waiting Times:

The Blue Mountains electorate is served by two hospital emergency departments (ED) located at Blue Mountains District ANZAC Memorial Hospital (BMDAMH) and Nepean Hospital.

It is reported to me on a regular basis that waiting times are frequently in excess of the four-hour benchmark. For patients who require hospital admission there is often a further wait while a suitable bed is found, thus creating bed-block in the ED.

Recently a patient who was suffering significant breathlessness waited around 12 hours before receiving treatment at the BMDAMH Emergency Department. I wonder how much excessive waiting times, as well as pain and anxiety, contribute to escalating levels of aggression experienced by our emergency department staff.

A registered nurse reported to me that 80 patients were awaiting assessment at Nepean Hospital emergency department on a recent Sunday evening. She told me that:

> *"Visits to the Nepean Hospital ED have doubled over the past two months. This only adds to the difficult conditions and stress for patients and staff. At the best of times, we are barely coping and people have long waiting times. We are serving a population that is growing and the level of their presentations is becoming more complex with higher degrees of acuity. I know the re-build of the ED is being planned but we need the expansion of services now before the whole system breaks."*

b) Waiting times for orthopaedic surgery:

When looking at overall results for elective surgery at Nepean Hospital, waiting times are slightly better than those of it's peers. However when you look at a break-down of results per surgery type, results look less positive.

Waiting times for knee and hip surgery are a subject of frequent complaint to my office. It is easy to understand why when you look at the figures.

In 2015–16, when compared to its national peer group, Nepean Hospital performed as follows:

- The median waiting time for elective surgery performed by orthopaedic surgeons was 51 days.
- 21.0% of patients waited longer than 365 days for elective surgery performed by orthopaedic surgeons compared to its national peer group performance of 3.7%.
- 28.2% of patients waited longer than 365 days for total knee replacement at this hospital, compared to its national peer group performance of 7.9%.
- The median waiting time for total hip replacement was 302 days at this hospital, compared to its national peer group performance of 96 days.

- 20.8% of patients waited longer than 365 days for total hip replacement at this hospital, compared to its national peer group performance of 4.1%.[2]

c) Public dental services:

Waiting times for public dental services remain a frequent subject of complaint from my constituents. There are high levels of social disadvantage in my electorate which places dentistry out of the hands of many. The most disadvantaged in my community are reliant on the public dental clinics at Blue Mountains and Nepean Hospitals.

Waiting lists for dental treatment are long forcing people who are in pain to wait for extended periods to receive basic dental treatment. Access to dentistry that may be considered more cosmetic in nature is not available to this group of people which may impact on their self-confidence, employment prospects, marginalisation, etc.

(d) Adopting a Person-Centred approach in the provision of health services:

With increasing numbers of people in our community living with chronic and complex illness, the need for greater coordination of health services is needed to achieve results and make best use of available resources.

The issue of communication between health professionals and patients and their families is a source of difficulty and complaint. If patients are expected to take responsibility for their health, effective communication is needed. A systemic approach is required to ensure effective communication of information, results, treatments, etc.

It is good to note that the NBM LHD has recognised the need for better planning, coordination and collaboration with regard to patients with chronic and complex conditions. I note that the NBM LHD is recruiting a nurse practitioner who will focus on healthcare coordination and planning for this group of patients.

The NBM LHD is introducing greater access to telehealth at Blue Mountains Hospital which will address some of the geographic issues that impact health care delivery and improve collaboration across the facilities, access to, and consultation with, specialist services and better use of existing staff resources.

(e) Cardiac Rehabilitation and the CALM Group:

These two group programs operate at Blue Mountains Hospital to promote patient well-being, provide health education and reduce preventable admissions to Blue Mountains Hospital. I am aware of the success of these programs and the benefits it provides participants. I am aware that both these programs face challenges due to staffing and other resource issues.

Today a constituent who recently had a heart attack contacted my office to inform me that there is a three-month wait for the cardiac rehabilitation. This 55 year old man is currently on leave from his job, however in order for him to return to work, he must

[2] https://www.myhospitals.gov.au/hospital/1152D2100/nepean-hospital/elective-surgery

complete cardiac rehabilitation. This case points to the costs of heart disease in our community and the urgency in addressing the waiting list for this group.

2011 - 2012 data points to the value of the CALM Group for patients living with Chronic Obstructive Pulmonary Disease (COPD). During this period there were 1,006 hospitalisations resulting from COPD. By ensuring the CALM program is sustainable, we can reduce expensive hospitalisations and improve the quality of life for those affected.

(d) Palliative Care Services in the Nepean-Blue Mountains

In the NBM LHD, cancer is the second highest cause of death with regional prevalence in adults the second highest ranking for NSW state. Cancer incidence is reflective of the state averages with the number of preventable cancer deaths in the region expected to increase rise to 758 in 2021 (from 663 in 2016) alongside population increases.[3]

I acknowledge the Palliative Care enhancements announced in the 2017 Budget. I am interested to learn what this means for services provided by the NBM LHD and the people of the Blue Mountains.

(e) Services for Older people:

> *Australia has an 'ageing population'. More people are living longer than ever before. People aged 65 or more are already a substantial part of the community – and this age group is expected to make up nearly a quarter of our total population by 2035.*
>
> *The Blue Mountains LGA has the highest median age in metropolitan Sydney (43.5). The area is also ranked third in metropolitan Sydney for percentage of the population older than 65 years (18.1%).*
>
> *Between 2011 and 2026, the age structure forecasts for Blue Mountains City indicate a 9.2% decrease in population under working age, a 62.7% increase in population of retirement age, and a 8.7% decrease in population of working age.*[4]

Critical to providing services to older people is accessibility and transport links.

The following issues have been raised by residents and other key stakeholders in the Blue Mountains as significant challenges in the provision of health services for older people:

(i) Access to rehabilitation facilities in the local area:

There is an in-patient rehabilitation unit at BMDAMH. This unit provides a safe and supportive environment, particularly for older people, with access to allied health services such as physiotherapy, occupational therapy and social work.

[3] http://www.nbmphn.com.au/Resources/About/130_0217-Needs-Assessment-A4_FINAL_WEB.aspx
[4] http://www.bmcc.nsw.gov.au/files/Ageing-Strategy-12July2017.pdf

However, it has been brought to my attention on a number of occasions that nursing ratios are less than adequate to deal with the increasingly complex needs of this group of patients. With an increasing number of elderly Australians living with dementia, the demands on this unit will continue to grow in complexity and number. Current staffing levels must be reviewed and addressed to ensure the safety and security of staff and patients.

The rehabilitation unit at Springwood Hospital is located in an old portable building. It is poorly equipped to meet current standards for rehabilitation services.

(ii) Dementia unit:

There are more than 413,106 Australians living with dementia. By 2025 the number of people with dementia is expected to increase to 536,164. Without a medical breakthrough, the number of people with dementia is expected to reach 1,100,890 by 2056. Currently around 244 people each day are joining the population with dementia. The number of new cases of dementia will increase to 318 people per day by 2025 and over 650 people per day by 2056. [5]

Dementia, whilst not exclusively an older person's disease, is strongly associated with the ageing of the population. Given the demographics of the Blue Mountains, this is likely to be an even bigger issue of concern for local residents, their health providers and families.

There are significant challenges in providing safe and appropriate care for people with dementia within the hospital environment. Ensuring their safety and security and those of others in the health care environment requires a purpose-built and secure dementia unit.

(iii) Hydrotherapy services – Springwood Hospital:

Currently hydrotherapy services are only available at Blue Mountains Hospital. The Friends of Springwood Hospital have made a case for hydrotherapy services at Springwood Hospital as an adjunct to effective rehabilitation services.

(iv) Transport:

The provision of patient transport services remains a major gap for elderly patients with chronic and complex health conditions. Many older people in our community, who are no longer able to drive, have difficulty getting to and from appointments at our local hospitals. This is a particular problem for those living in nursing homes and supported accommodation who are now ineligible for community transport.

The impact of this means increasing difficulty for ageing patients accessing healthcare services. Often the only mode of transport available to them is a taxi. Recently an elderly resident of a nursing home reported to me that she paid $220 for a one-way trip from her nursing home in Wentworth Falls to Nepean Hospital. Her

[5] https://www.fightdementia.org.au/statistics

only alternative was to forgo the appointment for which she had waited several months.

PART TWO: Mental Health Services:

Mental health in the Nepean-Blue Mountains Local Health District (NBM LHD):[6]

- Mental and behavioural disorders are the fifth leading cause of death in the NBM region, accounting for 4.6% of all deaths (2010-11).
- Male hospitalisation rates for mental disorder is highest in the NBM LHD, among the 15 NSW LHDs and significantly higher than all the metropolitan LHDs. Corresponding female hospitalisation rates are fourth highest amongst the 15 NSW LHDs and fourth highest among the eight NSW metropolitan LHDs.
- High suicide rates for middle-aged and elderly men (2.8 times the age standardised rate for women). There are increasing rates of suicide among youth with recent surveys indicating 7.5% of 12 to 17 year-olds have seriously considered attempting suicide in the previous 12 months (2013–14). Suicide rates for Indigenous Australians are high (2.25 times age standardised, 2001-2010) which is higher than the NSW average. Socio-economic disadvantage may be a suicide risk factor in the NBM region.
- Self harm represents the highest hospitalisation rate for males and second highest for females aged 15-24 compared with all other NSW metropolitan LHDs.
- A high proportion of Aboriginal and Torres Strait Islander people experience psychological distress whilst a relatively low proportion of Aboriginal and Torres Strait Islander people access psychological and psychiatric services.

From the Nepean-Blue Mountains PHN's MENTAL HEALTH NEEDS ASSESSMENT 2016/2017:

Across the region, low intensity mental health services are limited for children and youth. Other findings reveal a lack of care coordination, referral pathway coordination and case management. Discharge planning is not consistent, with a lack of coordinated follow up post discharge. There is an absence of sub-acute services across the region, particularly for youth. Long wait lists for public psychiatric services are compounded by psychiatric workforce needs.

Increasing the knowledge of general practitioners about available clinical and non-clinical services, and their referral pathways is a need as is culturally appropriate services for Aboriginal people and CALD populations.

Other specific populations requiring support for mental health included the homeless and prisoners upon release from correctional services and when transitioning to the community.

[6] http://www.nbmphn.com.au/Resources/About/130_0217-Needs-Assessment-A4_FINAL_WEB.aspx

Capacity issues within the System - Bed-Block:

With regard to in-patient mental healthcare there remains an ongoing pressure on bed availability. Whether it be beds in the PECC, the Nepean or Blue Mountains Mental Health Unit or access to the Community Mental Health Teams, the system is struggling to meet demand. In response to 'bed-block', staff, on a regular basis, are forced to make decisions to discharge or admit patients on the basis of bed availability.

Servicing the Blue Mountains community:

With two Mental Health Units in the NBM LHD, based at Nepean and Blue Mountains Hospitals, there are significant challenges in adequately staffing and servicing the community in the Blue Mountains.

I acknowledge the innovations adopted by the NBM LHD in the delivery of mental health services from Nepean to Blue Mountains Hospital. This includes:

The employment of a Nurse Practitioner to provide specialist mental health assessments after-hours (evenings and weekends). This complements the Clinical Nurse Consultant role which is based in the bleu Mountains ED and liaises closely with the in-patient unit and the community mental health teams.

The on-going difficulty in recruiting doctors (psychiatrists and registrars) to the Mental Health Unit at Blue Mountains Hospital has resulted in changes to the delivery of after-hours medical services.

There are no longer psychiatric registrars available after-hours at Blue Mountains Hospital. In their place, more extensive use of telemedicine from Nepean Hospital provides support to the after-hours medical staff working in the Blue Mountains ED during mental health assessments and admissions. I understand that any patient who requires a review by a psychiatrist are offered an appointment (of one hour or greater duration) via teleconferencing with a registrar based at Nepean Hospital. Further I am told that this is providing greater access and a faster service for patients and therefore reducing the stress of extended waiting times in the ED.

Psychiatric registrars continue to be present during business hours at Blue Mountians Hospital to work with other members of the team to develop, implement and review case plans for in-patients.

Step-down facility/Psychiatric Rehabilitation:

Currently there are no step-down facilities or residential psychiatric rehabilitation for mental health patients who have chronic and on-going conditions in the NBM LHD. In addition, the current difficulties which exist for vulnerable people who require social housing, places this particularly vulnerable group at risk of homelessness or living in unsafe and unsustainable housing. The combination of mental illness and housing insecurity is likely to impact negatively on mental health.

Rehabilitation and step-down facilities are required to ensure the right mix of services and a continuum of care and support for patients of the NBM LHD.

Allied health Positions:

In recent years any enhancements to the mental health budget of the NBM LHD have been directed to in-patient services with community mental health services receiving no enhancements.

Additional allied health staff have been provided to in-patient facilities. However there seems to be a question mark around the best and most appropriate use of the allied health workforce within the acute mental healthcare setting. As it was explained to me by a very experienced mental health practitioner:

> *"The time people are forcibly admitted to hospital and possibly psychotic - is not the time to bring about change for people, provide assessments, etc. It is much better to introduce people to Occupational therapists, psychologists, etc once they are stable and at home where they are much more likely to be able to engage with the process and take on the changes."*

Young People and Children:

There are no in-patient beds for young people and children in the NBM LHD with the nearest beds being located at Redbank House in Westmead.

We are very fortunate to have a highly skilled team at the Child and Youth mental Health Service. However, their resources are stretched to meet the growing needs of children and young people in our community who are experiencing distress and mental health conditions.

Also see section on Open Dialogue.

Peri-natal beds:

There are no peri-natal beds in the public system accessible to women in the NBM LHD. The closest peri-natal beds are available in the private mental health system at St John of God, Burwood. This seems inequitable, placing mothers and babies with significant peri-natal depression at risk.

Community mental health services:

As stated previously there have been no enhancements of community mental health services. The community mental health teams struggle with high caseloads.

However, I commend the NBM LHD on establishing the Assertive Treatment Team for people acute and chronic mental health issues. This team was funded out of monies which previously supported Hornseywood House in KIngswood. No enhancements were received to establish and sustain this service.

The Assertive Treatment Team has demonstrated significant benefits including reductions in bed occupancy and re-admissions to the Mental Health In-Patient Unit at Nepean and a proactive and integrated service for clients.

Unfortunately this service is only available to people on the plains and is not available to people in the Blue Mountains (as well as Hawkesbury and Lithgow Areas).

I recommend that a similar service be established in other parts of the NBM LHD including the Blue Mountains (Springwood and Katoomba Community Mental Health teams).

The Open Dialogue Approach to Mental health

> *Open Dialogue was developed in Western Lapland, Finland, in the 1980s. It involves a consistent family/social network approach to care, in which the primary treatment is carried out through meetings involving the patient together with his or her family members and extended social network.*
>
> *Open Dialogue emerged out of a decade long, organic process, while clinicians (including Jaakko Seikkula and Markku Sutela) searched for the best treatment for acute mental illness and, in particular, psychosis. Many of the changes they made along the way were reactions to encountering ambiguity and uncertainty. They decided to free themselves from searching for a non-existent truth, concentrating instead on curiosity and improvisation. Linked to this, they incorporated the recognition that language shapes our reality, and that one's language, and thought, is dependent on seeing the world through a personal 'lens'. The main aim of clinician involvement became the creation of a shared understanding of the problem, through a shared language.*
>
> *The Open Dialogue approach has spread across much of Scandinavia and other European countries including Germany, Poland, and Italy. In the USA, New York City's successful Parachute Project is founded on similar principles.* [7]

This approach is now being trialed in Australia, specifically at St Vincent's Hospital, Darlinghurst and the NBM LHD.

As one practitioner informed me:

> *International research has found that the role of families in the recovery of people with mental illness is currently undervalued by clinicians. This new approach hopes to turn this around through the establishment of new models of care and improved collaboration between individuals, their families and social and health care providers. Open Dialogue - if we do it properly - we will avoid the breakdown of family relationships and people will remain in the family.*

[7] https://www.psychologytoday.com/blog/hide-and-seek/201507/open-dialogue-new-approach-mental-healthcare

The newly appointed St Vincent's Professor of Mental Health Nursing, Professor Niels Buus, is implementing a research project to teach mental health staff the Open Dialogue model. He has also worked closely with the NBM LHD CYMHS team supervising and facilitating the implementation and establishment of Open Dialogue for young people and their families in the Nepean-Blue Mountains.

Training in Open Dialogue has been rolled out to staff in the NBM LHD Child and Youth Mental Health Service (CYMHS) and in community mental health with the Blue Mountains Community Health Team being trained in this model. However there are no additional funds or other resources for its implementation.

Critical to the success of the Open Dialogue model is coordination of family meetings, services, etc. Community partners are an important ingredient too to ensure an integrated, collaborative and comprehensive approach. Unless there are additional resources allocated to the coordination of individual family plans, Open Dialogue is unlikely to get off the ground and produce the cultural change and positive results that have been identified as outcomes.