Thursday, 20 August 2020

Questions on notice

Transcript:

Ms CATE FAEHRMANN: But the reality is that that situation, if somebody in a different part of Sydney—say, someone who lived in, let us just say, Lane Cove who had a 12-centimetre liver tumour—they would probably be able to get in to get that treated. Embolised—is that the word you used— Associate Professor LEVY: Yes.

Ms CATE FAEHRMANN: —sooner than two weeks. Would you expect that?

Associate Professor LEVY: Yes, I would expect that but I do not—you know, it is hard. We do not know every single thing and Liverpool is probably the best. We have more resources than our other colleagues in other hospitals in south-western Sydney but we are a referral centre from those hospitals. If you wanted on notice to look at the waits for those urgent things, they are not measured. The surgical targets do not measure urgent inpatient waiting-for.

One-third of our patients coming through the emergency department are overseas-born. About a quarter of them do not speak English and you know you are a junior doctor trying to work out if you are patient, who is waiting for an endoscopy because they came in with a bleed, is going to be done today and trying to communicate that and they are not even on your ward and the endoscopy room is already full because they take patients from Campbelltown and sometimes Fairfield—sometimes Fairfield goes to Bankstown. We are too thin and a building will not fix that. We have enough rooms. And, look, you know the chief executive tries her best to listen to what is the most pressing thing but there just is not an equitable slice of the pie.

Response

Thank you for the opportunity to respond to this issue and I apologise for the delay, as I had not properly understood this as a question posed.

In my role as Chair of MSC, I have no access to data and our meetings are to provide clinicians an opportunity to raise issues. For many years the major issue is around insufficient funding balanced against relentless growth poses. The issue precipitated the funding of an external WESTIR review. It is quite hard for us to get data. We are clinicians but have no staff to collect data. The lack of KPIs in many fields that we see as an important measure of the health of service delivery is also a barrier as the district has no genuine interest in focussing on non KPI metrics in our experience.

The issue of waiting for things is very important but with far fewer data managers and departmental business managers in our district (than other districts) the information is very difficult to get. The Telegraph reported on May 6 2020 that an analysis of waiting times for elective surgery was starkly different, 110 days for Sydney LHD and 292 for SWSLHD, nearly 3 fold difference. There is no measure for endoscopy waiting times, but we are not meeting our category A requirements at all across the district, although there has been some increased activity to address this in the last month.

Patients in hospital waiting for an interventional radiology or acute surgical procedures are frequently cancelled multiple times as the bookings are adjusted to try and meet the acute and elective demand. Interventional and emergency surgery likely need two rooms running and an anaesthetist available support the work every day. There have been many patient complaints about

this issue. Within liver cancer, patients do wait longer than in other districts for work up and treatment. We are the population epicentre of liver cancer and our patients get a first class service, until the point where they become second class citizens waiting for a spot for a treatment supported by an anaesthetist, which may take weeks.

Oncology services have been pushing for years to increase the opening times of their cancer chemotherapy treatment centre, without luck due to budget.

I am aware through Liverpool Hospital Clinical Council meetings that there are approximately 75 individual briefs requesting enhancement for service, usually FTEs, as yet unfunded. These lists sit with our executive but cannot be supported as there is no real growth money beyond one or two items (or none at all as in the last 12 months). There are many services affected and the executive has indicated that they would be willing to provide this list if required. Further briefs are rarely put up now, as it is futile in the absence of growth enhancements.

I remain hopeful that the bottom line of our funding gap compared with other districts cannot be ignored. Unless we have enough funds to have data collectors and managers I worry requests for data to solve this will fall on busy (not deaf) ears. Some KPIs might assist. I remain hopeful that funding a hospital to deliver a populations health care (ie measure funds per head of population in the district) is a simple clear measure. We find no evidence to support the assertion that this is justified by patient wanting to move to other districts for treatment. We would hope that going forward the funding metric is tested against that basic principle.

Thank you for all the work you are doing. Please contact me if you would like further information.

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