Submission No 25

INQUIRY INTO CURRENT AND FUTURE PROVISION OF HEALTH SERVICES IN THE SOUTH-WEST SYDNEY GROWTH REGION

Organisation: Campbelltown and Camden Emergency Department Executive

Date Received: 22 April 2020

Submission to the Inquiry into the current and future provision of health services in the South-West Sydney Growth Region

Introduction

This submission is made on behalf of the Emergency Department Executive Team (ED Executive) from Campbelltown and Camden Hospitals. The ED Executive is a multidisciplinary team of experienced emergency clinicians and managers who provide leadership to the Emergency Departments across both sites. We welcome the opportunity to make this submission as we have been concerned for a long time about the low levels of resources and staffing in the Emergency Department, and Hospital, when compared with our workload and when matched against most of our peers.

Campbelltown and Camden Hospitals operate under a single management structure and the ED's operate as a single service across both sites. All Emergency admissions (from Campbelltown and Camden) go into the inpatient wards at Campbelltown. As a collective, our combined ED saw 95,500 patients in 2019, making it the busiest in NSW. Campbelltown ED alone saw 83,500 patients which is the 5th busiest department in NSW.

In this submission our chief concerns are;

- The disparity in health funding across Sydney
- The lack of transparency in the funding levels
- The unbalanced approach to reporting health outcomes without any reference to capacity
- The geographical bias in location of health services in Sydney
- The disparity in staffing at Campbelltown when compared to other Emergency Departments, and
- The urgent need to further invest in Health Services in SWS

Transparency and Reporting

We will be providing details and perspectives addressing the listed terms of reference below. Firstly, however, we would like to speak to some more fundamental issues that have contributed enormously to the creation and maintenance of the disparity in health funding that exists across the Greater Sydney region. Those issues are the lack of transparency in funding and the unbalanced focus in Health Service reporting. It is our belief that even if the inquiry was unable to directly address any of the other listed concerns, the development and promotion of a more transparent system of funding and reporting would, in and of itself, lead to substantial improvements for the Health Services of South West Sydney.

The lack of funding transparency makes it impossible to appraise the level at which a hospital should, or could, be functioning. There is no way for services across different hospitals and across different LHD's can be compared with respect to their resourcing. That information is not made available. We believe this lack of transparency will be evident to the committee members as you try to access hospital data in any form that allows for meaningful comparison of funding and capacity (apart from time performance measures as we will detail below). Hospitals are regularly compared in terms of performance without any reference to their respective levels of funding.

There is a long-held truism that says, 'you have to measure to manage'. This is seen in any substantial project or process where key data points are measured to inform and drive decision making. Closely related to this is a reporting function where the important drivers and outcomes are made available. Those elements which are considered most important are the ones which are reported most widely.

Campbelltown and Camden Emergency Departments April 2020

We can learn a lot about what is measured and what is reported in Emergency Departments and Hospitals.

The Emergency Department Key Performance Indicators include;

1. Emergency Treatment Performance (the 4-hour rule)
2. Triage Category seen time (% of triage category patients seen within the ideal time)
3. ED Length of Stay
4. Time to treatment
    - Stroke thrombolysis
    - AMI thrombolysis/stent
    - Analgesia
    - Sepsis - time to antibiotics

The Hospital reportable indicators are focussed on;

- Length of stay by diagnostic related groups
- Hospital acquired infections
- Falls
- Representations
- Compliance with complaint response times/IMS
- Excess leave balances
- Overdue policy reviews
- Mandatory education compliance

The Bureau of Health Information, one of the four pillars of the Ministry of Health, produces extensive reports published on their web site (www.bhi.nsw.gov.au). In these reports you can learn about;

- Hospital performance, including
    - Emergency ETP
    - Emergency treatments start times
    - Ambulance offload times
    - Elective surgery waiting times
    - Patient feedback with specific reference to;
        - ED
        - Paediatrics
        - Maternity
        - Adult admitted patients
- Mortality
- Patients seen via ED
- Ambulance arrival numbers
- Hospital admission numbers

While this is all excellent data, provided in great detail, the focus is clearly on;

- Throughput, in terms of numbers seen and time taken,
- Experience, in terms of satisfaction surveys, and
- Outcomes, in terms of mortality and other complications

What is missing from all this data, is any reference to capacity. There is no reference to the capacity in terms of size, beds, staffing, services or funding. All the focus is on how we delivered our services, and none on our ability or capacity to deliver those services. The Hospitals in NSW are compared with the unspoken assumption that all are resourced at the same level and that the comparison is valid.

This is not true. There are vast discrepancies between hospitals with respect to their capacity. This capacity difference is seen in terms of staff numbers, bed base, level of available support services, access to diagnostic and treatment options, level of community services, access to private hospital beds, and budget. This variation in capacity is not proportional to workload.

These capacity elements are all available in the system but are not appear to be measured and are certainly not reported. This lack of transparency and the unbalanced reporting of performance, without reference to capacity, allows the unequal distribution of resources to remain invisible and unquestioned.

An easy example would be to compare the Children's Hospital Westmead which saw 64,000 ED patients in 2019 with Campbelltown ED which saw 83,500 patients in 2019. The CHW ED has 6 consultant and 2 Fellow (senior trainees about to be consultants) shifts each day. In addition, 21 trainee doctor shifts. Campbelltown has 5 consultant shifts, no Fellows, and 25 trainee doctor shifts. Overall, Campbelltown has 1 more shift per day, with more junior staff and fewer consultants, to see an additional 19,500 patients. Expressed in a different way we have 3% additional staff to see 30% more patients.

Hospital	CHW	Campbelltown
Annual Census	64,000	83,500
Consultants per day	6	5
Fellows per day	2	0
Trainees per day	21	25
Total shifts per day	29	30

As introduced above, if the committee was only able to do one thing then we request that a data set be developed and reported that allowed for comparison of resourcing alongside performance then we would be well placed to address the historical inequalities of resourcing that exists in SWS.

Regarding each of your Terms of Reference, we will be providing data relevant to Campbelltown and Camden Emergency Departments.

(a) an analysis of the planning systems and projections used by NSW Health in making provision for health services to meet the needs of population growth and new suburbs in the South-West Sydney Growth Region;

Population projections are a central part of the planning that occurs within SWS. We also use other data sets such as population health e.g. disease prevalence in the community and outcome comparisons.

We have known for a long time that SWS has been underserviced in terms of healthcare. The WSROC report from 2012, which focussed on 'Western Sydney' but included the Liverpool, Fairfield and Bankstown LGA's, showed that there was poorer access to healthcare and poorer health outcomes based on a number of parameters:

- Higher death rates from Cardiovascular, Diabetes and avoidable causes per 100,000 population
- Higher incidence of Obesity and Smoking as preventable risk factors
- Fewer public hospital beds per 100,000 pop.

- There is less access to Aged care and Mental Health beds.
- Fewer public hospital staff and increased hospital presentations per 100,000 pop.
- Significantly fewer private hospital beds per 100,000 pop. For every private hospital bed in the WSROC region there were 2.5 beds in the rest of Sydney.
- The combined effect of fewer private and public hospital beds leaves the region with 25% fewer beds.
- The ED treatment times were longer.
- The wait for cancer and other surgeries was longer.
- There were 40% more residents per GP.

More recently Liverpool Hospitals Medical Staff Council commissioned the WESTIR report. The executive summary is copied here, showing;

- *Funding is not equitable:*
    - *South Western Sydney LHD had one of the lowest total annualised expense budgets per resident by LHD when compared with other regions in Greater Sydney.*
    - *The low costs per National Weighted Activity Unit (NWAU) showed that the LHD can deliver a cost-effective health care, however this impacts the ability to deliver timely and effective care to patients with complex needs.*
    - *The LHD also had the lowest average cost per acute encounter indicating that the region had less funding to deal with complex cases outside the NWAU system.*
- *Socioeconomic challenges of the community are greater:*
    - *Liverpool LGA and the South Western Sydney region has the highest rates for the following indicators that place a greater burden on our health system:*
        i. *Higher one parent families, greater number with low household incomes ($999 or less per week), lower labour force participation, higher socioeconomic disadvantage, high total fertility and crude birth rates, higher adult smoking and obesity and need for assistance with core activities.*
        ii. *Liverpool LGA and the South Western Sydney region has the lowest levels of English proficiency when compared to other Greater Sydney regions. This has impacts which are not accounted for, including the cost of clinicians and interpreters in the cascade of care that need more time to obtain medical consent, medical history, social history and accurate record of medications.*
        iii. *South Western Sydney has also taken over half of NSW's humanitarian settlers in recent times which have their own unique socioeconomic and health challenges.*

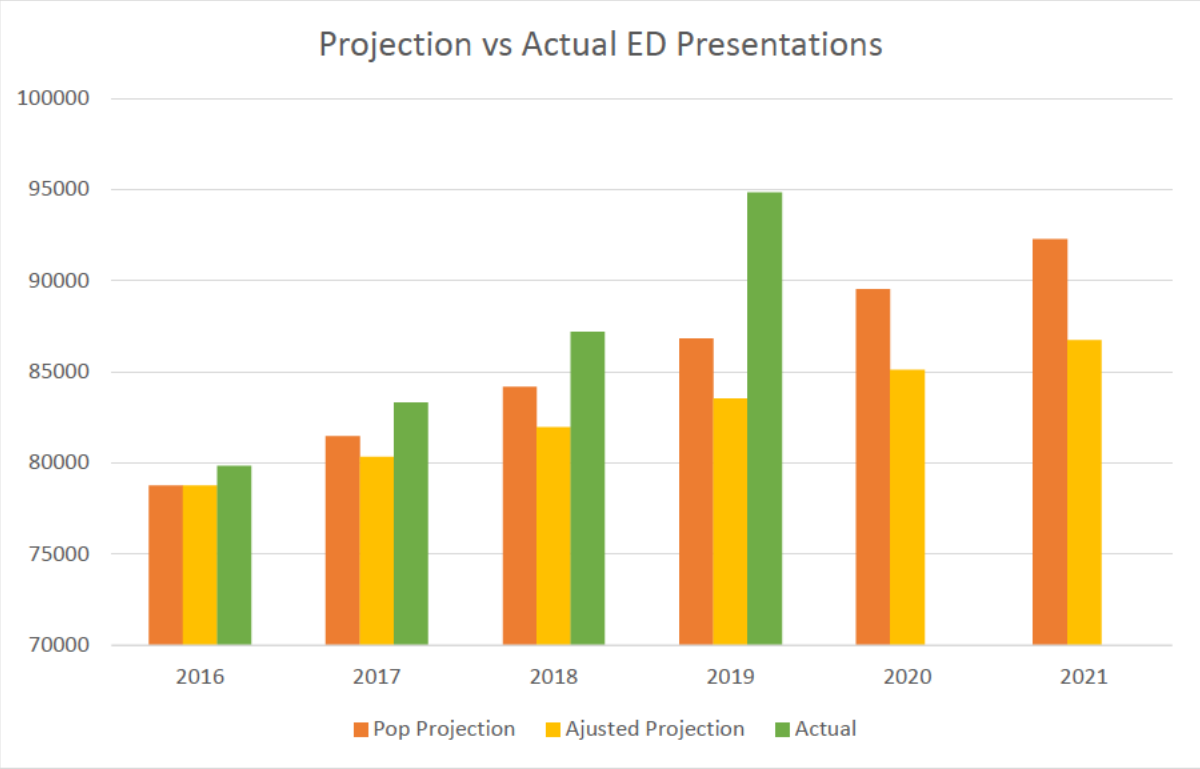
All these factors contribute to more complex (and therefore more expensive) health care challenges for the district.

- *Alternative for medical care outside the hospital system is reduced:*
    - *The South Western Sydney region has the lowest rates of private hospital beds and private health insurance hospital cover compared to other regions in Greater Sydney, placing further strain on the public hospital system.*
    - *Liverpool LGA and the South Western Sydney region has a significantly lower number of medical and health services, particularly when compared to inner city areas.*
    - *The much lower number of non-specialist (general practitioners) and specialist medical practitioners in the South Western Sydney region compared to rates for other Greater Sydney regions and NSW is likely to impact multiple elements of the patient healthcare journey before and after hospital.*

In summary, this document provides evidence that the funding is unfairly low compared to other health districts. It also illustrates the community's socioeconomic and cultural/language challenges as well as the comparative lack of alternative healthcare providers and thus reliance on the public hospital system.

These two reports show a picture of service gaps that have existed for years.

The following graph was developed by the ED Executive. This graph reflects the current planning process for the Stage 2 redevelopment. It compares the population-based estimate of demand (orange) with the numbers carried forward into planning the ED bed base (yellow), with the actual measured presentations (green). It demonstrates the widening disparity between projected and actual presentations to Campbelltown ED since 2016. This is the data upon which the current redevelopment was modelled.



Pop Projection = estimates of presentations based on population data
Adjusted Projection = reduced estimate of presentations used to plan the size of the ED and the hospital
Actual = measured ED presentations over the first four years of the redevelopment

The increase in Emergency Department presentations, and therefore the number of required ED treatment spaces, can be predicted from projected population growth. This is based on established ratios endorsed by the Australasian College for Emergency Medicine. However, during the redevelopment planning process the allocated number of ED treatment spaces (based on population and evidence) was reduced by 8%. The rationale for this reduction was the expectation of large scale 'hospital avoidance' measures. There is no evidence base that any such large-scale diversions are feasible and our actual measured increases confirm that this assumption of hospital avoidance is not valid. This results in a new ED that will be under powered to manage the actual population and presentation increase.

The capital investment in the Stage 1 and 2 redevelopments at Campbelltown has been very welcome. We need to be clear, however, it is mostly going towards meeting existing need and, as seen in the graph above, will not get us ahead of anticipated demand.

We were recently provided with an updated population projection, by LGA, which shows massive population growth, particularly in the Camden LGA.

ASGS 2019 LGA	2016	2021	2026	2031	2036	2041
Bankstown*	204,537	219,307	235,267	246,681	252,275	263,000
Liverpool	211,983	251,322	291,187	328,447	380,085	441,427
Camden	80,264	127,647	153,299	180,071	236,255	307,727
Fairfield	205,675	209,983	216,693	232,681	254,821	264,588
Campbelltown	161,566	180,051	194,039	212,366	227,946	249,262
Wollondilly	49,854	54,140	58,482	66,381	73,477	82,513
Wingecarribee	48,998	50,048	50,837	51,345	51,555	51,496
SWSLHD	**962,877**	**1,092,498**	**1,199,804**	**1,317,972**	**1,476,414**	**1,660,013**
NSW Total	**7,732,858**	**8,414,978**	**9,011,010**	**9,560,567**	**10,077,964**	**10,572,696**

This information shows SWS growing by 72%, compared with 37% growth across the whole of NSW. It is worth pointing out that Campbelltown Hospital services all the acute healthcare needs for Campbelltown, Wollondilly and Camden LGAs: population that starts at 291,684 and grows to 639,502.

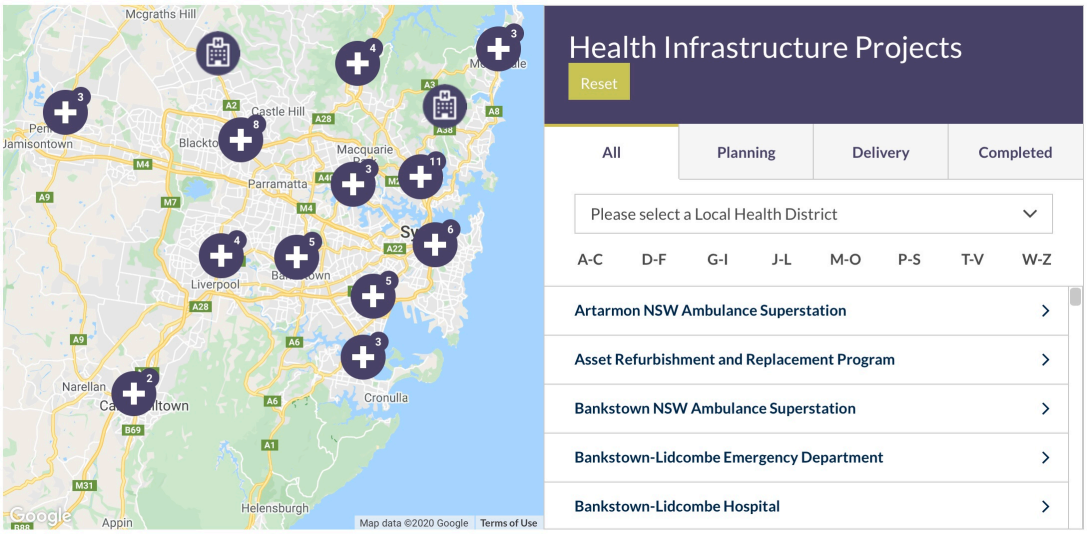
(b) An analysis of capital and health services expenditure in the South-West Sydney Growth Region in comparison to population growth since 2011;

We acknowledge, and greatly appreciate, the $630M government capital investment in redeveloping Campbelltown Hospital. This will see an 82 bed ED and several new clinical buildings upon completion of Stage 2 in 2022. This is a significant and welcomed investment in our facility. We also acknowledge large capital investments at Liverpool and Bankstown and smaller investments at Fairfield and Bowral.

This investment, however, does not redress historical bias in funding towards the central, north and eastern parts of greater Sydney. The local expenditure is greatly exceeded by the redevelopments at Royal North Shore ($1.27 Billion), Northern Beaches Hospital ($2.14Billion), Prince of Wales Hospital ($720M), RPAH ($750M), St George Hospital ($277M), Hornsby ($265M) and more.

As seen in the Health Infrastructure graphic copied below there are 18 projects occurring to the West and South West of Paramatta (the population centre of the Sydney region) and 41 projects to the East of Paramatta, including the Bankstown projects.

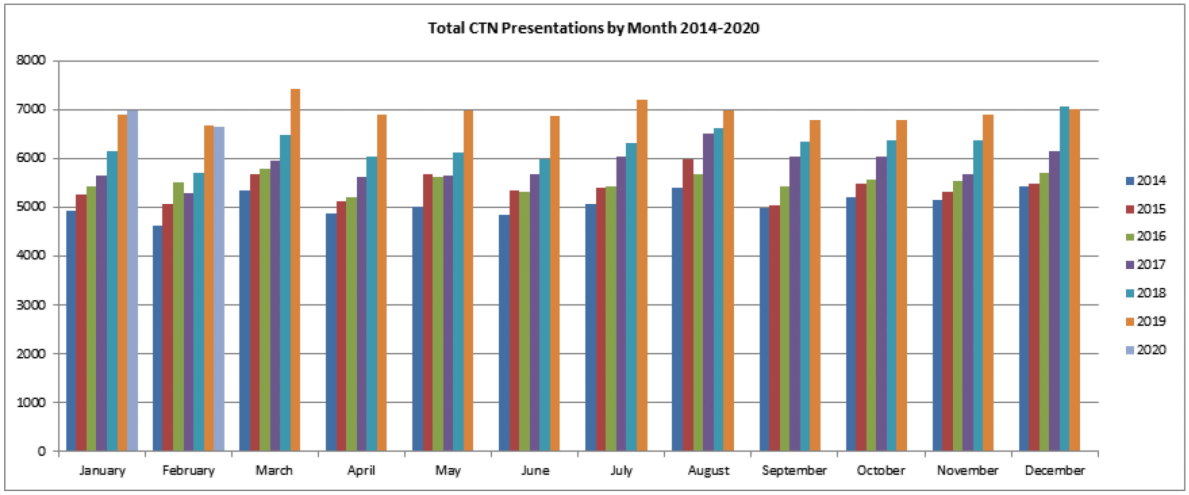
Health Infrastructure delivers all major health capital projects over $10 million on behalf of the NSW Government. Our projects span across metropolitan and regional NSW and reach as far north as Byron, as far West as Broken Hill and down south to Bega.

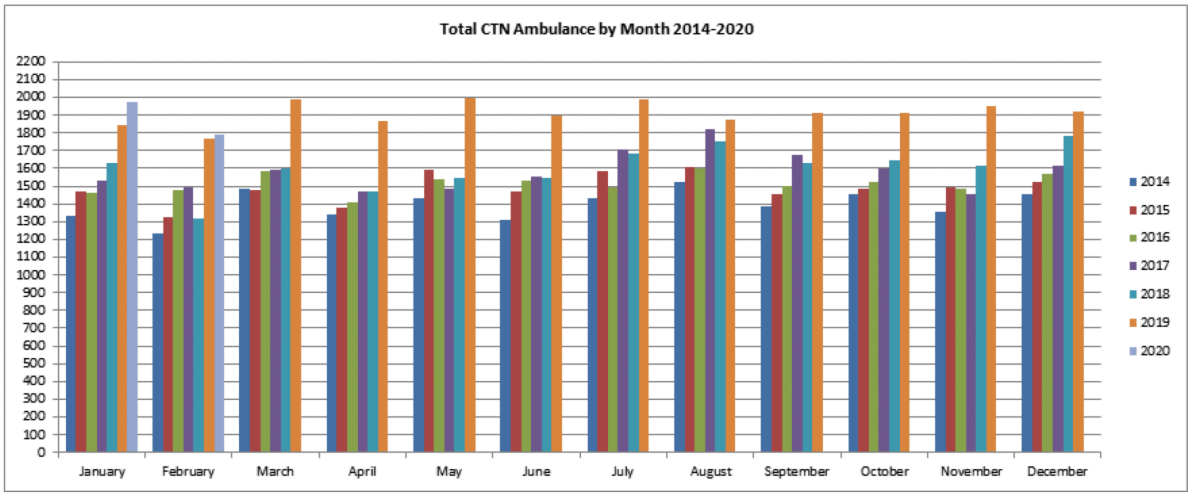


Our capital investment is welcome, but we are still being funded at rates that are not in proportion to the population distribution in Sydney, nor in a way that addresses the historical deficit.

Camden hospital is a perfect example. Much of the last 20 years has been spent reducing services and debating which departments, including the ED, should close and indeed whether the hospital itself should close. This discussion is borne out of the concern that the facility and the staffing are not able to service the acute needs of the local community safely. We have seen a progressive reduction in maternity services, acute medical services and emergency services (Camden has been on ambulance bypass for 5 years). Looking at the population table above Camden is expecting a 383% growth in population and will be the second most populous LGA in SWS. Camden is not planned for any substantive capital enhancement despite the massive growth and obvious need.

The capital investment alone is only part of the equation. Any capital investment needs to be matched with an equivalent commitment to staffing. It is the people who provide the care. Since 2011, Campbelltown ED has grown from seeing 55537 to 84000 in 2019, representing an increase of 55% in absolute terms. During that same time period, the increase in staff has not kept pace and routinely staffing enhancements are for the provision of new services, such as the Emergency Short Stay Unit, and not simply to meet the increased demand in patients.





We request that the Inquiry reviews the total budgets for different facilities across Sydney and the capital investments by LHD. We have looked at some of the available staffing data, detailed later in the report. In terms of capital and staffing investments SWS has not been treated in an equitable fashion when compared with other regions in Sydney.

We struggle, as senior health professionals working in SWS, to remember that is it the same government that funds hospitals like Royal North Shore Hospital as Campbelltown. The differential funding cannot be explained through greater need occurring in North Sydney, it can only be understood through the lens of bias and of the social and political influence that can be exerted by suburbs with high socioeconomic status

(c) The need for and feasibility of a future hospital located in the South-West Sydney Growth Region to service the growing population as part of the Aerotropolis land use plan;

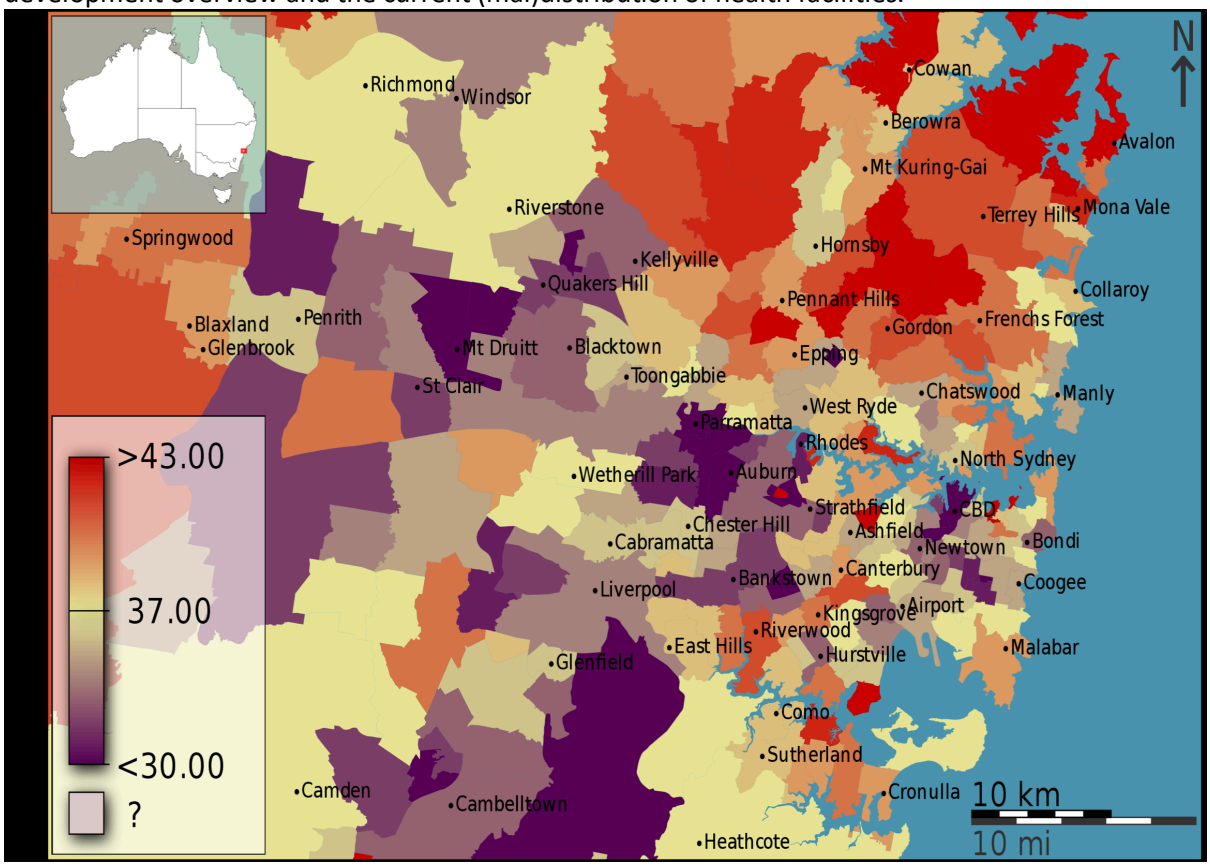
The information presented above details a clear need for service expansion and investment in capital and health staffing. There is a need to proceed with Stage 3 of the Campbelltown redevelopment as the current redevelopment will only meet a proportion of the growing demand. There is also a need to develop and expand Camden Hospital back to a functional state. It can still provide selected services

in partnership with Campbelltown but must be restored out of its current limited palliation/rehabilitation scope.

Even with Stage 3 it is not possible for the expanded Campbelltown and Camden Hospitals to meet all the acute needs of the Aerotropolis and there is a ceiling beyond which building larger single hospitals introduces inefficient and unduly complex facilities.

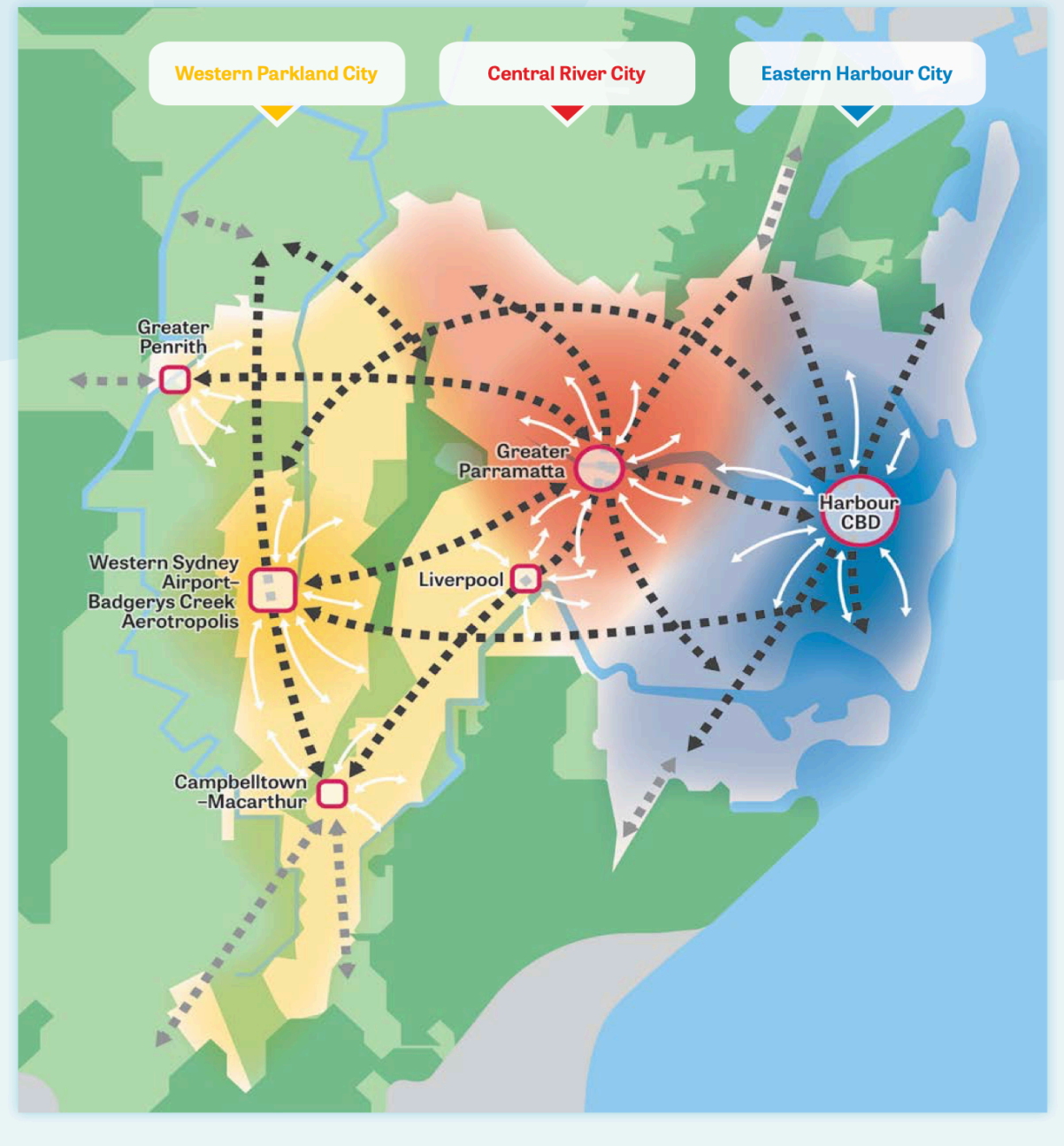
We support the building of a new hospital to meet acute needs and address some of the current mismatch between services and population.

Some of the particular features related to the South Western Sydney population expansion are shown in the following images. This includes the age distribution across Sydney, the 'Three Cities' development overview and the current (mal)distribution of health facilities.



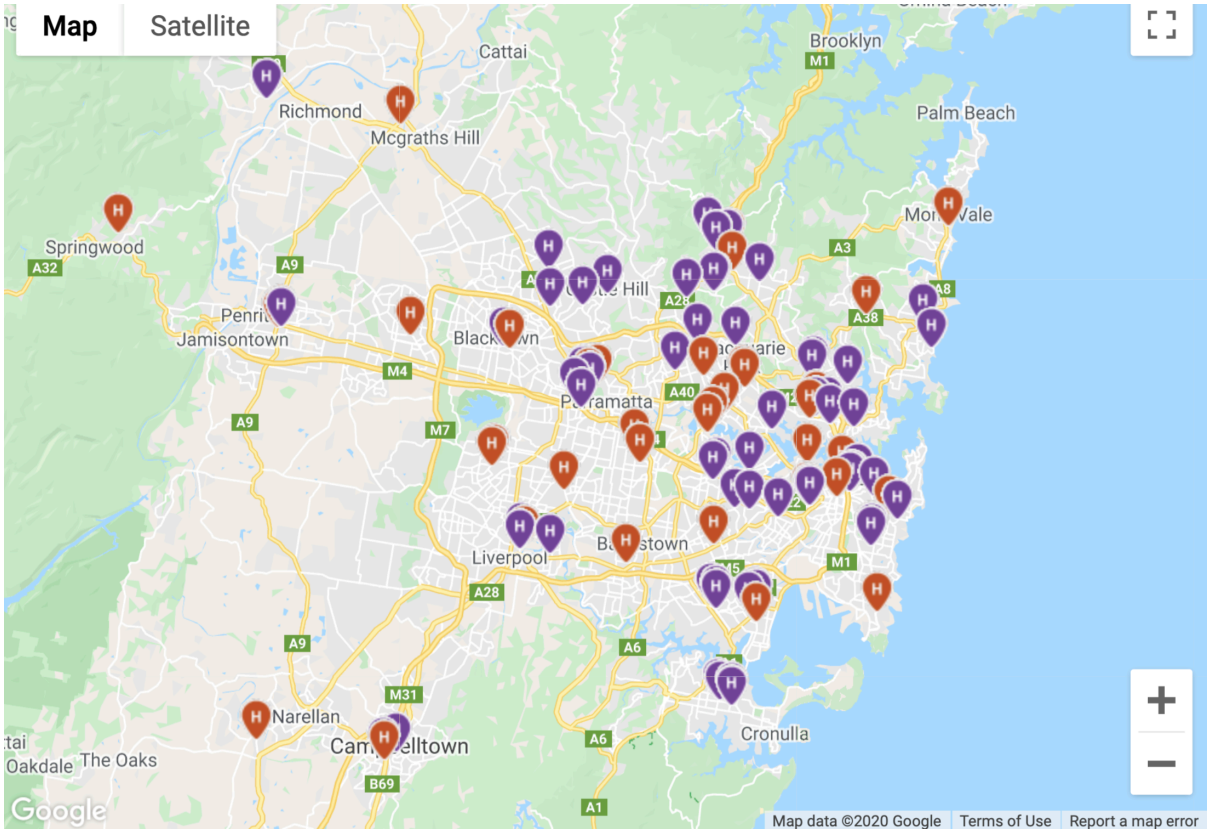
Median age by postal area 2011
https://en.wikipedia.org/wiki/Demographics_of_Sydney

This map displays the large numbers of young families (expressed in terms of median age) as you move to the West and South West of Sydney.



The Three Cities development and the Aerotropolis

https://gsc-public-1.s3.amazonaws.com/s3fs-public/greater-sydney-region-plan-0318.pdf



Public (Orange) and Private (Purple) Hospitals across Sydney

https://www.myhospitals.gov.au/search/hospitals

In this last image (taken from the My Hospitals website) we draw attention firstly to the large hole in the map where the Aerotropolis will be developed, devoid of healthcare facilities, and secondly to the fact that Paramatta, in the middle of the map, is the population centre of Sydney. The disparity of distribution of healthcare facilities is clear. A simple exercise in covering each half of the map sequentially shows to dominant location of healthcare facilities in the North and East of Sydney.

(d) an investigation into the availability and shortfall of mental, community and allied health services in the South-West Sydney Growth Region;

Our daily lived experience working in Campbelltown ED is one of marked shortfalls in mental health (MH) services. This is true across the whole Macarthur region. As a consequence, in Emergency we regularly have mental health patients waiting over 24 hours for inpatient mental health services. In some circumstance's patients have waited in Emergency for over 100 hours to be placed into an appropriate inpatient MH facility. This fails to meet the health care needs of this vulnerable patient population.

The current MH reporting dashboard shows we average **54** patients every month who spend more than 24hrs in the ED. This masks the full extent of the issue as these patients commonly spend more than 2 days in ED (they are only counted once) and the longest length of stay recorded was over 100 hours!

Mental Health Emergency Department Dashboard - Campbelltown Hospital
2019 - 2020 Financial Year

Data Element	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	YTD Mthly Avg	YTD Total
Number of Mental Health Presentations to ED	328	349	360	392	380	371	347	351					359.8	2878
Number of Admissions to an acute Mental Health Ward	115	102	87	103	113	102	102	95					102.4	819
Number of Admissions to an Acute MH Ward < 4 Hours	15	3	2	7	8	4	17	11					8.4	67
Percentage of Admissions to an acute MH Ward < 4 Hours - Target is 81% from July 2016	13.0	2.9	2.3	6.5	7.1	3.9	16.7	11.6					8.0	
Percentage of MH ED Patients admitted to an Acute MH Ward	35.1	29.2	24.2	26.3	29.7	27.5	29.4	27.1					28.6	
Number of Mental Health Patients Discharged from ED (excludes transfers to wards)	171	218	238	257	239	243	223	225					226.8	1814
Number of Mental Health Patients Discharged from ED in < 4 Hours (excludes transfers to wards)	48	65	20	67	50	60	63	64					54.6	437
Percentage of Mental Health Patients Discharged from ED in < 4 Hours (excludes transfers to wards)	28.1	29.8	8.4	26.1	20.9	24.7	28.3	28.4					24.3	
Average Duration of Stay in ED - in hours	13.7	15.4	15.9	14.3	15.6	14.0	13.0	13.2					14.4	
No. MH ED Presentations with a triage to discharge time of > 24 Hours - Target is '0'	41	79	69	64	21	63	46	48					53.9	431
No. MH ED Presentations with a triage to discharge time of > 12 hours (new 2017-2018) no target set.	110	146	168	159	74	161	137	134					136.1	1089
Data is based on Admitting Medical Service, Mental Health Ward Admissions and Mental Health Diagnosis														

Last year we reviewed data that shows Campbelltown Hospital has more mental health patients spending greater than 24 hours in ED per month than the entire Sydney LHD has in all their EDs per year.

It is an indictment on the availability of MH beds in South West Sydney that most MH admission that are admitted via ED at Campbelltown never actually go to the MH inpatient units, more than 50% are discharged home directly from the ED.

(e) a comparison of the per capita operational expenditure allocated for the health services and hospitals between the South-West Sydney Growth Region and other local health districts across metropolitan Sydney since 2011;

As referenced in our introduction this information is not readily available to us as clinicians. We hope that you are able to review the facility budgets and staff numbers and make a comparison across Sydney. The WSROC and WESTIR reports reference some of the funding shortfalls.

(f) a comparison of the staffing allocations at health services and hospitals between the South-West Sydney Growth Region and other local health districts across metropolitan Sydney since 2011;

One aspect that constrains the level of investment and staffing in Campbelltown Hospital is its Peer Group classification. The Australian Institute of Health and Welfare groups hospitals into Peer Groups, the purpose of this grouping is explained in their 2015 document, copied here;

What are hospital peer groups and why use them?

Australia has over 1,300 hospitals. These range from large public hospitals with hundreds of beds (delivering a wide range of services in major cities), through the many private sector day hospitals with a dozen or so beds (focusing on a limited range of services), to public outpatient clinics in remote areas. Australia's hospitals, and the services they provide, are not easily described or summarised. However, hospital peer groupings can facilitate the description of Australia's hospital resources, and help with summarising information on the organisation and provision of hospital services, as they are defined as groups of similar hospitals based on shared characteristics.

When presenting health performance and other data, it is also important that valid comparisons are able to be made. For hospitals, a peer grouping allows comparisons that reflect the purpose, resources and role of each hospital. Hospital peer groupings define and delineate groups of similar hospitals based on shared characteristics. According to Byrne et al. (2009), peer groups:

> …help control for systematic risk and constraints presented by various influences on a hospital's finances or clinical outcomes. These constraints and risk are generally not easy for administrators to change within a reasonable time. Hence, the rationale for peer groups is to place hospitals or health systems facing similar structural and patient characteristics together and facilitate 'like-to-like' fair comparisons.

This means that peer groups are often used to present comparative information in a way that substitutes for risk adjustment; that is, it is a method of stratification.

Peer groups can also be used to define scope of data collections and analyses, including specifications for performance indicators.

Austra an Inst tute of Hea th and We fare 2015. Austra an hosp ta peer groups. Hea th serv ces ser es no. 66. Cat. no. HSE 170. Canberra: AIHW.

The grouping is stated to compare 'like-to-like'. For large public hospitals the grouping commences with group A1 hospitals and moves down the alphabetical categories. The peer groups not only provide reference points for comparisons but frequently are used in planning and resourcing decisions where group A1 hospitals are prioritised.

The notion that Campbelltown is appropriately located in Group B hospitals as a 'like-to like' comparison is fundamentally flawed. Campbelltown's activity exceeds all of the other B group hospitals (often by double) and has us in the upper section of the A1 Hospitals.

The average number of ED presentations for the B peer group in the latest BHI quarterly was 12,320, the average number of ED presentations for the A1 peer group was 18,769. Campbelltown ED saw 20,675 presentations in that same period.

It is important that Campbelltown be relocated into the A1 Group for many reasons, not the least is it effects on Nursing Hours per Patient Day (NHPPD). The formula to determine your nursing staff for general wards includes the hospitals Peer Group classification. If you are in A1 you receive 6 Nursing Hours per Patient Day, if you are in B (like Campbelltown) you receive 5.5 NHPPD, If in C you receive 5 NHPPDS etc. This is a concrete example of how the staffing allocations are being constrained at Campbelltown through incorrect Peer Group location.

Regarding our Medical Staffing numbers, we have produced the following table from several comparison hospitals based on their Emergency Department rosters. In the table we have included their ED presentations and shown it relative to their staffing levels.

Campbelltown and Camden Emergency Departments April 2020

Hospital	Annual presentations	Consultants per 24 hours	Average presentations per consultant shift per week	Total doctors per 24 hours	Patients per doctor shift per week
Liverpool	95103	7	259	38	48.3
Campbelltown	84530	5	343	30	53.9
Royal North Shore	89694	8	217	42	40.6
Royal Prince Alfred	83335	6	266	30	53.2
Prince of Wales	62572	6	196	28	42.7
St George	82828	7	224	Not available	
Northern Beaches	55335	7	203	36	39.9
Westmead	78677	7	217	42	35.7

The table shows that Campbelltown has the lowest number of consultants shifts when compared to presentations and also the lowest number of total doctor shifts when compared to presentations. This comparison, however, does not tell the full story as Campbelltown does not have access to other acute services that support the Emergency Department. These surrounding services add to the capacity of the ED to manage their patient load.

The table has Campbelltown and RPAH seeing similar numbers of patients with similar staffing. However RPAH has access to the following services not available at Campbelltown;

- 24-hour Cardiac Catheter Lab
- Greater ICU capacity
- Extended hours imaging diagnostics like Ultrasound
- Interventional Radiology
- Full complement of specialty services like Vascular Surgery, Neurosurgery, ENT, Opthalmology, Dermatology
- Dedicated Allied Health within the Emergency Department
- Technical Assistants within the Emergency Department
- A full complement of Australian trained doctors (Campbelltown is dependent on International Medical Graduates for 80+% of the ED medical staff)

We do not begrudge our Emergency colleagues this increased level of service, we do criticise the system that allows this inequality to develop and continue.

In 2018 Campbelltown ED applied to the Australasian College for Emergency Medicine for an increase in our accreditation level. The level of accreditation is the way the college endorses a department to provide training in Emergency Medicine. This accreditation both recognises the capacity of a department to deliver training and assists in its ability to recruit trainees. Emergency Trainees naturally are drawn to departments who are accredited at a higher level. The higher accreditation levels also allow a department to train the doctor for a longer period, aiding staff retention.

The following extracts are from the 2018 ACEM Accreditation report for Campbelltown Hospital

"FACEM staffing is limited after hours, particularly on weekends. At times FACEM presence comprises only one per shift. For a department with an annual census approaching 76,000, this is significantly below that recommended by ACEM's "Guidelines on Constructing and Retaining a Senior Emergency Medicine Workforce" (document G23): 4 FACEMs both on day and evening shift. Unsurprisingly, trainee feedback indicates a clinical workload where service provision severely limits the opportunities for constructive teaching, particularly after hours...."*

"...Improvements and enhancements at Campbelltown ED since ACEM's last inspection are impressive. The enthusiasm and the desire to deliver high quality training is evident. The leadership team is commended for establishing sound foundations for tenured accreditation as a 12-month site, acquired only 3 years ago. Transition to an 18-month status is supported by activity, casemix and training infrastructure / governance. However, its heavy reliance on a CMO workforce, limited protection of 4 hours per week of trainee teaching time and insufficient FACEM numbers limits the feasibility of this transition in such a short period. "

*census for 2017

(g) an investigation into the health workforce planning needs of the South-West Sydney Growth Region to accommodate population growth to 2050;

We have included the latest population projections in the earlier section.

Health workforce planning needs to be;

- Proportionate to the population growth
- Equitable and without postcode bias
- Specific to particular health needs of the community.

The need for an expanded workforce should be clear but we believe the current processes to be falling short with respect to all three of the parameters listed above.

(h) a review of preventative health strategies and their effectiveness South-West Sydney Growth Region since 2011 and the required increase in funding to deal with childhood obesity;

Limitations in primary care and community health services are part of the significant overall problem for SWS. As noted in the attached reports we have higher incidence of smoking and diabetes, low socioeconomic status and its associated poor health literacy.

While there is a valid debate in many parts of the healthcare sector regarding investment in primary versus hospital-based healthcare, such a binary does not reflect the large need for investment in both the community and the hospitals in SWS.

(i) a comparison of clinical outcomes for patients in the South-West Sydney Growth Region compared to other local health districts across metropolitan Sydney since 2011,

In developing the Clinical Services Plan for the current (Stage 2) redevelopment for Campbelltown hospital the population and public health data showed;

- An expected 71.8% increase in population from 2011 to 2021
- Residents are being required to travel out of area to receive 40% of the inpatient care they need.
- Emergency Admission per inpatient bed significantly higher than other Sydney Hospitals
- Potentially avoidable hospitalisations are higher in Campbelltown than the rest of NSW
- Campbelltown smoking rates (17%) are higher than the rest of NSW (14%)
- The all cancers age standardized incidence is higher in Macarthur than the NSW average (183 vs 166)
- The socioeconomic index for areas (2011) indicates that some of the poorest communities in NSW live in the Macarthur region.
- Higher hospitalisations for smoking, obesity, coronary heart disease, stroke and chronic obstructive pulmonary disease in Campbelltown.
- Lower rates of cancer screening
- Rates of diabetes 32% higher than the state average

SWS, and Campbelltown in particular, have significant Aboriginal populations with Aboriginal and Torres Straight Islander peoples comprising 1.8% of the SWS population. The Campbelltown region includes areas with large Aboriginal communities and high social disadvantage such as Claymore and Airds.

LGA - Region	Aboriginal population (2016 census)	Total Population (2016 Census)
Bankstown	1412	171429
Campbelltown	5971	157006
Camden	1933	78218
Fairfield	1483	198817
Liverpool	3012	204326
Wingecaribee	954	47882
Wollindilly	1552	48519
SWS Totals	**16317**	**906197**

Data resource: 2016 census population & Department of Health (MBS data)

Our Aboriginal communities are a group which have social and health disadvantage and continue to have a lower life expectancy to non-Aboriginal people.

These extracts are from the SWS Aboriginal Health Plan 2017–2021 and details some of the many determinants of poor health for our Aboriginal population.

Smoking

- In 2015, 34.9% of Aboriginal people in NSW aged over 16 are current smokers, compared to 12.9% of the non-Aboriginal population[xiii]. Smoking rates for the non-Aboriginal population are decreasing, whilst remaining more steady for the Aboriginal population[xiv]
- 39.6% of Aboriginal women in SWSLHD smoke during pregnancy, compared with 8.2% of non-Aboriginal women[xv]
- 15.5% of Aboriginal babies born in SWSLHD have a low birthweight (under 2,500g) compared to 6.4% of non-Aboriginal babies. A significant risk factor for low birthweight is maternal smoking[xvi]

Consumption of alcohol at risky levels

- In 2015 40.1% of Aboriginal people aged over 16 in NSW consume alcohol at levels posing a lifetime risk to health, compared to 25.5% of the non-Aboriginal population of the same age[xvii]

Consumption of fruit and vegetables[xviii]

- In 2015, 53% of Aboriginal people aged over 16 in NSW do not eat the recommended amount of fruit per day
- In 2015, 92.8% of Aboriginal people aged over 16 in NSW do not eat the recommended amount of vegetables per day

Participation in adequate physical activity

- In NSW in 2015, 39.1% of Aboriginal people aged over 16 participated in adequate physical activity compared with 43.2% of non-Aboriginal people[xix]

Adult immunisation[xx]

- In NSW in 2014-15, 67.9% of Aboriginal adults aged over 65 were immunised for influenza, compared with 72.1% of non-Aboriginal people of the same age
- In NSW in 2014-15, 28.9% of Aboriginal adults aged over 65 were immunised for pneumococcal, compared with 48.6% of non-Aboriginal adults aged over 65

Suicide

- Nationally, Aboriginal people are 2.6 times more likely to commit suicide than non-Aboriginal people[xxi]

For Aboriginal residents of SWSLHD, circulatory disease is the leading cause of death, followed by cancer. In SWSLHD, 14.0 Aboriginal people per 10,000 population die from preventable causes, compared to 10.6 per 10,000 of the non-Aboriginal population[xxvii]. These diseases can be impacted by lifestyle and behaviour factors such as smoking, poor nutrition, low rates of physical activity, unmanaged chronic disease, low participation in screening and adult immunisation. Barriers to accessing the health system such as mistrust, fear, cost and lack of transport can also result in delayed diagnosis and treatment, resulting in earlier death are an issue.[xxviii]

https://www.swslhd.health.nsw.gov.au/pdfs/2021-AboriginalHealthPlan.pdf

Campbelltown and Camden Emergency Departments April 2020

The Bureau of Health Information has recently produced a report into mortality (death rate) after hospitalisation

http://www.bhi.nsw.gov.au/BHI_reports/mortality/Mortality-following-hospitalisation

This report reviews the mortality rates for seven key conditions;

- Acute Myocardial Infarction
- Ischaemic Stroke
- Haemorrhagic Stroke
- Congestive Heart Failure
- Pneumonia
- Chronic Obstructive Pulmonary Disease
- Hip Fracture Surgery

The report uses the 30-day Risk Standardised Mortality Ratio (RSMR) as its main measure. A low RSMR is good and means a lower death rate. The list of high performing hospitals with lower RMSR is dominated by the central, northern and eastern regions of Sydney, seen in this excerpt.

> Six hospitals had lower than expected mortality for at least two conditions:
>
> - **Blacktown**: AMI; and pneumonia
> - **Prince of Wales**: AMI; haemorrhagic stroke; and chronic obstructive pulmonary disease (COPD)
> - **Royal North Shore**: AMI; and COPD
> - **Royal Prince Alfred**: CHF; and COPD
> - **Ryde**: CHF; and hip fracture surgery
> - **St Vincent's**: haemorrhagic stroke; CHF; pneumonia; and COPD.

Even more troubling is the following extract from the reports introduction;

> ## Mortality ratios across local health districts
>
> There are some metropolitan local health districts (LHDs) such as Northern Sydney, South Eastern Sydney, Sydney, and St Vincent's Health Network, where one or more hospitals had RSMRs lower than expected. These LHDs had no hospitals where RSMRs were higher than expected.

The ultimate measure for any health service is its mortality. The implication of the BHI report is that if you go to hospital in Northern Sydney, South Eastern Sydney, Central Sydney or St Vincent's you have a lower chance of dying after you are treated.

We believe that in SWS we have some of the finest, most dedicated, clinicians who are comparable to any in other high performing health services. It is the ingredients detailed in our submission above, the workload and resources available, which limit our capacity to deliver healthcare at the standard we want, and at the standard our community deserves. These limitations to our capacity are why SWSLHD is not in the list shown above with RMSR lower than expected.

Summary

The lack of transparency in heath funding and unbalanced reporting has contributed to a system that has historical and ongoing bias towards the Central, Northern and Eastern LHD's in Sydney. Hospitals such as Campbelltown and Camden are faced with a large workload that is growing faster than any other part of NSW yet does not have the capacity to meet this demand. The rate of investment falls behind what is required to meet the future demand and continues the geographical bias. We commend to the Inquiry the following recommendations;

- A system of reporting be developed to provide transparency in health funding across LHD's
- That health funding be distributed according to population and population growth
- The reporting of health system performance to include capacity reporting in addition to throughput, experience and outcomes
- Campbelltown Stage 3 redevelopment should be fast tracked and reviewed to ensure it meet the expected population growth
- Camden Hospital be redeveloped to meet the predicted 383% population growth
- Staffing of units such as the Emergency Department be subject to a parity measure across NSW Health that matches staffing to workload and removes historical and postcode bias
- Campbelltown Hospital be moved into the more appropriate A1 peer group
- Camden Hospital data be reported in all BHI reports

We again thank the Inquiry for this opportunity and for their time and consideration of our submission.

sincerely

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Director of Emergency, Campbelltown and Camden Hospitals

On behalf of the Campbelltown and Camden Emergency Department Executive.