Submission No 222

INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NEW SOUTH WALES

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Date Received: 8 December 2020

d) Wait times. The KPI of 4 hours in emergency, was created for political reasons "to demonstrate that wait times were reduced" The result is a target to either have patients released or admitted. Where there is a bed shortage or incapacity to deliver acute care outcome, patients are being released when further observation is in patients best interest.

This has also resulted in elderly patients who may have presented by ambulance, needing transport or taxis to get home often with no-one at their home to monitor.

Cases are prevalent and common where they present the next day after being discharged to comply with the " efficiency" KPI

The reports on 4 hour KPI as a measure of efficiency can be counter productive to clinical outcome and patient welfare.

Experienced emergency doctors report of the "NEW REGIME" of triage ordering a battery of tests with the doctor allocated then reviewing those results, rather than first spending time taking a patients history and determining whether this is similar or recurring issue. Instead massive costs and sometimes unnecessary and tests are being ordered, which effectively clogs up the system and adds to wait times.

The experienced doctor will first take a history, review medication, determine if this is a new or recurring symptom, then determine what tests are required to either confirm suspected diagnosis or explore where there remains queries of cause or risk. less experienced staff are ordering the tests.

e) There needs to be more accountability with integrated planning in a similar manner to local government in NSW. The premiers plan for health outcomes, may effectively take on the same basis as the Community Plan for LGAs. The lack of outcome based planning that considers socio economic and demographic data that is readily available from either census or Local Councils ought to inform Clinical Services Plans (CSPs) but instead lack of standardisation via a template for all local health districts, results in CSPs becoming a bottom draw "wishlist" largely composed by medical staff, albeit via a consultation process so that it ticks a box. There is a question mark over the capability and skill diversity of area health boards, who tend to be a rubber stamp to the whims of CEOs of the local health district.

Asset planning or capital expenditure by NSW Governments, tend to be politically motivated.

It is unacceptable that public money is promised at election time for political opportunism, without a business case that is transparent and linked to both a clinical services plan and achievable asset and personnel targets that are based on a prioritised outcome.

It is unacceptable that Clinical Services Plans, Trauma Validations and audit of Acute Care Capacity are allowed to be out of date, or not reviewed. There needs to be some non-negotiable requirements for all Local; Health Boards as part of their oversight, with

reporting and validation to NSW Health. So that this is manageable, Health Districts to have scheduled completion dates for critical planning instruments.

Eg Hunter New England Local Health Districts may be scheduled a different date to South Coast, so that there is achievable expectations and review and sign off.

A review of planning systems that have an integrated methodology that is standardised and outcome based, may be required as a replacement for what is currently in place.

Local Environment Plans for Local Government requires sign off at Ministerial level and have some standardisation but Local Health Districts appear to have less accountability and oversight.

It is easier to apportion money to high population metro areas as it reaches more people, but there is less regard for regional areas.

A macro view of the problems associated with NSW urbanisation points to Regional areas as a solution to the infrastructure issues that plagues the high population areas.

Positioning of service delivery based on predicted growth areas and to target specific priorities around demographics and vulnerable can provide a fulcrum to people migrating from metro to regional areas.

Eg areas such as Mid North Coast, where there is a higher proportion of retirees, points to coverage for vascular, cardiac acute care responses.

Aboriginal population concentration, requires intervention programs, to reduce diabetes, alcohol related, ENT as examples.

Current planning is reactionary rather than outcome based.

A planning and reporting process where there is accountability and justification for funding both of a capital nature & recurrent, with an outcome based business case where the funding request is aspirational in nature.

l) Other.
When students from regional areas commence study in metro, the chance of them returning to their home area other regions can be hampered by them being "coupled" or entrenched in the metro life style.

Targeted recruitment or both undergrad nurses and doctors, Federal incentives such as HECs discounts, Bonding and or NSW scholarships that are conditional upon service for a bonded period in regional areas, increases the chance of " country" kids returning. "Grow our own" is the concept.

Succession planning and greater empathy and encouragement of VMOs. incentives to train graduates either under VMOs or registrars.