Submission No 79

THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO CROSS-JURISDICTIONAL HEALTH REFORM AND GOVERNMENT CONSULTATION WITH REMOTE, RURAL AND REGIONAL COMMUNITIES

Organisation: Mid North Coast Local Health District (MNCLHD) Local Health Advisory Committee

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The implementation of Portfolio Committee No. 2 recommendations relating to cross-jurisdictional health reform and government consultation with remote, rural and regional communities.

Health outcomes and access to health and hospital services in rural, regional and remote New South Wales. Portfolio Committee No. 2 - Health

Thank you for the opportunity to review and provide comment on the recent report from the Portfolio Committee No. 2. I feel privileged to be a member of the MNCLHD Local Health Advisory Committee (LHAG), as I have done with its previous iteration (MNC Consumer Reference Group) and the various committees, forums and reviews that I have contributed to, including the Mental Health Consumer Advisory Group, the Falls Prevention committee, as well as the Safe Transition of Care and the development of the Suicide Pathway.

It is not my intention to make comment on all 43 Recommendations outlined in this Report. Instead, I have placed comments related to the various Findings, as expressed on pages 14 - 16.

As a general comment, shared at this stage of my feedback, and reflected against specific Findings and Recommendations, it is my direct experience that the MNCLHD welcomes consumer and community engagement, and that this indeed is the premise of the Local Health Advisory Committee (LHAC). It is a concern that this experience seems not to be more broadly experienced across Local Health Districts.

Comments a **Recommendation 42, 43 and 44** are concerning. It is my experience that inclusion of the LHAC and genuine community consultation, including that relating to LHAC representation and membership, reach of existing communication approaches are a marker of effective engagement. **Chapter 7** on Governance is welcomed together with ongoing resourcing of the LHAC. Notes at **7.44 and 7.45** are not the experience within the MNCLHD. Rather there is a commitment to providing information to local communities on service provision, resourcing and opportunities for engagement and feedback. The comments regarding the mechanism to measure community engagement are noted, and I feel that the LHD is sensitive to such. Recent changes to meeting procedure and reporting were initiated by LHAC members, and has streamlined discussion. The inclusion at **7.66** is of concern. Rather than a limitation to effective community consultation, communication to and from the LHAC is central to the forum. It is my experience of the comments at **7.46** are at odds to the local experience, with the LHAC

having access to and receive information on health and hospital service outcomes, and are invited to actively participate in health service planning , as with recent presentation on Care Led Recovery Strategy.

By way of summary, I have referenced my comments against the Terms of Reference, Findings and Recommendations. I welcome your contact should you wish to discuss further.

As noted in the covering email, inviting comment on the Report, I am supportive of

1. Long term strategic planning between NSW and Australian Government to improve health services in NSW regional areas.
2. Collaboration between NSW and Australian Government on services or training programs.
3. NSW consultation with health stakeholders and communities.
4. NSW to prioritise health and regional communities in government decision making.

Terms of Reference

(b) In welcoming focus on health outcomes for people (as noted in **Finding 10**), the MNC LHAC has considered for some time how outcomes for patients living in the MNC compare to those in metropolitan NSW, with a view to highlighting health issues of concern, calling for increased or parity resourcing and learning from initiatives in metropolitan LHD's.

(g) The MNC LHAC has expressed ongoing review of recruitment and retention challenges and welcome a broader view. As discussed at **Recommendation 11** address to these issues with require a long-term commitment.

(h) Inclusion of issues associated with 'ramping' would be appropriate.

Findings

1 This has been widely discussed in the LHAC and under the previous Consumer Advisory Group, particularly as related to health outcomes and chronic disease.

2 While access to services continues to be a concern across LHD's, address to improve access has been an ongoing priority of the LHAC. The LHAC requests and welcomes reports that address access as well as receives feedback on implementation of those approaches.

4 Under-resourcing of medical staff has been considered under a broader discussion as it addresses recruitment and retention as it effects service allocation. (**Recommendations 7, 8, 9. 10).** I note the recent announcement of a skills-audit by the Australian Government as going towards this Finding.

5 This is an ongoing matter that impacts from the current funding model.

6 Activity-based funding may not be the most appropriate approach.

12 Issues relating to provision of regional access to cancer services has been a matter of concern to the current LHAC, and the focus of previous CRG's and investigations, and this is reflected in the development of strategic plans and operational planning and delivery. As an example, the development of a cancer centre in the LHD, and most recently commencement of lower-intensity care services at Kempsey District Hospital in response to community consultation that identified gaps and challenges faced with transport.

16 and 18 It has been the experience in the LHD that implementation of virtual care has integrated with more traditional face-to-face delivery of services.

17 Members of the LHAC have been active in raising matters that relate to identification of indigenous babies, and encouraged completion on birth certificates to circumvent issues that may impact in later life.

19 The existence of the LHAC, regular community forums and willingness to share data and information attests to transparency and accountability rather than the statement at **Finding 19.**

20 Rather than a culture of fear as noted at **Finding 20** the MNC LHD encourages employees to contribute to the review of patient safety, staff welfare and services. Staff wellbeing is frequently discussed at LHAC forums when receiving reports on service initiatives. Willingness for transparency on matters that relate to staff safety is demonstrated by the inclusion of risk management reports detailing current and emerging risks and updates on action taken.

21 It is the experience of the LHAC that there is strong, open, and genuine consultation between the LHAC and the Board and management. The LHAC is chaired by a member of the LHD Board, and concerns and any recommendations are communicated to the Board and senior management.

22 The LHAC regularly receives publications that concern discharge planning, inviting feedback and contribution. Recent contributions to the Total Knee Replacement and Total Hip Replacement protocol are an example of integrated planning with a focus on targeted information to patients prior to admission and how delivery of the service will affect hospital stay and ongoing management and recovery.

Recommendations

2 Review of IPTAS is welcomed. While the MNC geographic location is not as strong an impost as with patients from remote areas, it does remain a barrier to services within the LHD as well as when referral to metropolitan based services is indicated. Reports received by the LHAC and communication to the LHD is directed to strategic allocation of services, as mentioned earlier in this document in the delivery of cancer related services.

5 Active engagement with community groups is the basic tenet of the LHAC, reflected in the Terms of Reference and commitment to an annual planning forum.

8 Social determinants of health, particularly as related to social impacts and health outcomes are an ongoing concern in LHAC discussion.

25 My previous membership of the Mental Health Consumer Advisory Group (MHCAG) provided insight into access to and delivery of mental health services.

30 Creative use of telehealth demonstrates communication between specialists, health services and patients.

32 The use of indigenous artwork in all documents and communications, signage at facilities and Acknowledgement of Country in meeting procedure demonstrates the commitment to inclusion. The development of the Aboriginal Health Strategic Framework 2024 – 2034 is central to addressing issues that relate to health care and health outcomes. Installations of indigenous art at the Macksville District Hospital and a cultural space at Kempsey District Hospital are examples.

The comments expressed in this document reflect my experience of the LHAC and other forums and projects of the MNCLHD.

Regards

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