

From the President's Office
Dr Kean-Seng Lim
GAICD FRACGP MBBS



27 Sept 2019

Emeritus Professor Richard Henry AM FRSN

Independent reviewer on behalf of NSW Health

L16, Tower B, Zenith Centre, 821 Pacific Hwy Chatswood, New South Wales 2067

By email only: R.Henry@unsw.edu.au; Sarah.Morton2@health.nsw.gov.au

Independent Review of Health Services for children, young people and families within the NSW Health system

Thank you for the opportunity to comment on the Independent Review of Health Services for children, young people and families within the NSW Health system.

AMA (NSW) welcomes this review, which will provide the NSW Government with an important opportunity to ensure the state's strategic health plan is delivering high-quality, effective and safe care for NSW children, young people and families.

Following the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals ('the Garling Inquiry'), the Coalition Government announced reforms to the structure and governance of the system in 2011. The reforms were designed to empower Local Health Districts (LHDs) by devolving some management and accountability from the Ministry of Health for the delivery of health services in their area. As a result, there have been changes in the overall governance of services for children, young people and families.

LHDs and specialty health networks (SHNs) were made accountable for meeting annual obligations under service agreements, while the Ministry of Health was responsible for setting the policy direction, allocating resources and monitoring performance across the system. Meanwhile, the Agency for Clinical Innovation (ACI) and the Clinical Excellence Commission (CEC) are responsible for providing guidance across a range of areas including standardisation of care, new models of care, supporting improved clinical care and safety and quality.

The Ministry set the policy direction in its *Healthy, Safe and Well, A Strategic Health Plan for Children, Young People and Families 2014-2024*. In addition to that overarching strategic plan, NSW Health has produced several policies, frameworks and guidelines to inform paediatric clinical care.

Despite these comprehensive protocols, there remains a gap between policy and implementation. This gap is linked to devolution of the system. Devolution has meant LHDs are responsible for providing services to meet the needs of their local community. As a result, LHDs were required to

Australian Medical Association (NSW) Ltd

AMA House, Level 6, 69 Christie Street, St Leonards NSW 2065 | PO Box 121, St Leonards NSW 1590
t: 02 9439 8822 | f: 02 9438 3760 | e: enquiries@amansw.com.au | www.amansw.com.au | ABN 81 000 001 614

have separate paediatric wards. However, chronic underfunding of hospitals has resulted in LHDs falling short of established guidelines. For example, clinicians confirm that contrary to NSW Health Clinical Practice Guidelines for the care of children and adolescents in NSW Health acute care facilities, adults continue to be treated in designated paediatric wards. Hospital bed shortages combined with low volumes of paediatric patients often necessitate this ongoing practice.

Another ongoing problem cited from practitioners is the increase in children sent from local hospitals to specialist children's hospitals. Surgery, anaesthetics and nursing have become increasingly specialised, with generalist services less likely to treat children. While there is a recognition that paediatric patients should be treated at local hospitals, the reality is it's cheaper and easier to send them to NSW's major specialist children's hospitals. For families, this means longer travel times and increased wait times for treatment as specialist children's hospitals work through the backlog of paediatric patients. The increased demand on the services provided by the children's hospitals also means treatment of babies and children who really do need specialist care is also delayed.

Medical practitioners note that a significant amount of paediatric surgery is done in the private system, and it is therefore unclear why this activity is not possible in the public system. One possible explanation is ongoing confusion about what services can be provided at local hospitals and which cases should be referred. Clinicians also indicate the decision to treat a paediatric patient at a local hospital often comes down to the doctor available that day and their level of expertise in delivering care to paediatric patients. Providing paediatric care requires significant training, and the relatively small volumes of paediatric patients in some hospitals mean some doctors may not have the level of training required to adequately care for paediatric patients. In some hospitals, where providing paediatric surgery has been extensively reviewed, there remains limited capacity for day cases only.

This is not a new problem and solutions such as creating a hub and spoke model which would allow general paediatric surgery to be supported in other hospitals has yet to be fully implemented. The hub and spoke model, in conjunction with a strong model of care for services outside the major specialist children's hospitals is needed to ensure paediatric patients are treated close to home and pressure on specialist children's hospitals is alleviated. AMA (NSW) also calls for state-wide planning and rural workforce development to improve care outside of metropolitan Sydney.

CARE COORDINATION

As acknowledged in our previous submission regarding the draft Terms of Reference, AMA (NSW) suggests that in addition to looking at care provided in hospital settings, the review and strategic plan should more clearly define linkages with Primary Health Networks, general practices, primary care services, other specialists and the community.

The National Action Plan for the health of children and young people, released in 2018, provides a roadmap for a national approach to improve and ensure the health and wellbeing of all Australian children and young people. It seeks to build the foundation for the implementation of a series of policies, interventions and approaches aimed at improving health outcomes for children and young people. These are intended to drive action at the national, jurisdictional and local levels.

Australian Medical Association (NSW) Ltd

AMA House, Level 6, 69 Christie Street, St Leonards NSW 2065 | PO Box 121, St Leonards NSW 1590
t: 02 9439 8822 | f: 02 9438 3760 | e: enquiries@amansw.com.au | www.amansw.com.au | ABN 81 000 001 614

While the plan outlines what needs to happen to improve outcomes for children, it doesn't provide the 'how'. Thus, implementation of these strategies remains a challenge. Despite these shortcomings, AMA (NSW) supports the goals outlined in the plan. Particularly given the shortcomings in the current system.

Our healthcare system struggles to meet the needs of paediatric patients because of fragmentation and episodic models of care. Paediatricians should have central oversight of patient care, particularly in the management of surgery.

LHDS and PHNs should be working cooperatively to make it easier for patients and their doctors to access the system. General practitioners also find it difficult to engage with the hospital-based paediatric system, particularly in terms of access to services. Ongoing engagement with GPs is a priority to improve delivery of services closer to home and provide optimum care for children. Sharing health information and care plans across all health care providers and with the patient, parent and/or caregiver is an important component of care coordination.

DEVELOPMENTAL DELAYS

Early childhood interventions benefit children with developmental delays. Parenting and family support, as well as specific therapies for children can facilitate learning physical skills for everyday life and new behavioural and social skills. These therapies are often intense and take time to achieve results. However, early childhood interventions and support therapies cannot be triggered until children have been assessed and diagnosed. There is increasing frustration among patients and doctors about the unacceptable waiting times between referral, assessment, and access to services. In some instances, children are waiting up to 12 months to access services. These delays severely impact the potential benefits of early interventions.

Expansion of the paediatric primary care workforce is needed to improve screening and identification. This includes general practitioners, as well as early childhood health nurses, midwives, practice nurses, remote access nurses and Aboriginal Medical Services. Funding and training in awareness, screening, identification, support and co-ordination of services is central to improving access and early intervention.

Increased awareness of the Medicare rebates that can be accessed is needed, as well as improved incentivisation schemes. General practitioners indicate that none of the new Practice Incentive Program Quality Improvements' measures focus on paediatrics, and they are concerned by models such as Headspace, where the interface with the GP only happens to trigger funding.

NSW needs greater coordination between NDIS funding and Medicare, as current structures are extremely difficult to navigate for patients and clinicians alike.

CHILDREN'S MENTAL HEALTH

Child and adolescent access to mental health services is another area of significant concern. There is growing need for dedicated paediatric mental health beds and direct admission into hospitals.

Australian Medical Association (NSW) Ltd

AMA House, Level 6, 69 Christie Street, St Leonards NSW 2065 | PO Box 121, St Leonards NSW 1590
t: 02 9439 8822 | f: 02 9438 3760 | e: enquiries@amansw.com.au | www.amansw.com.au | ABN 81 000 001 614

Current hospital procedures for admitting a child for mental health services are too restrictive and cause unnecessary delays in treatment and access to care.

There are well documented workforce shortages in psychiatry in NSW; child psychiatrists are particularly stretched with too few working in the NSW public health system to adequately meet the growing mental health needs of this demographic. Children and adolescents in the 12-24 age group are not well supported, and this represents a major risk to their ongoing health.

CASE STUDY: IMPROVING TRAINING AND FUNDING

The waiting list for multidisciplinary team assessment of high-risk children remains far too long in all Australian jurisdictions. The children from the highest risk communities and families (such as those with a high Adverse Childhood Experience or ACE score), are usually the ones who are least likely to be able to access services, particularly specialist services.

I have a Level 3 ASD patient that came from a very dysfunctional family with all sorts of psychosocial issues (ice addiction, DV, incarceration – a very high ACE score). Eventually FACS took over his care and he is now being managed in a crisis approach, where he is in a rental house and they are still trying to find him permanent accommodation two months later. His lack of care and poor management has led him to being severely obese, probably malnourished, doubly incontinent, major dental issues, and massive behavioural problems, including violence (he needs three to one care 24/7).

The NDIS continues to have major issues with both access (particularly those with communication, cultural and intellectual barriers to navigating the system, including those from low socio-economic areas and those with high ACE scores) and availability of services. I feel strongly that the underspend on the NDIS in the recent budget was unacceptable, and this money should not just go back into consolidated revenue but be invested in the sector to which it was promised, to improve the situation.

LHDs and PHNs (including Health Pathways) need to work cooperatively, but this also needs to be part of a larger strategy, including improving training and funding for paediatric primary care (including early childhood health nurses, midwives, practice nurses, remote access nurses, Aboriginal Medical Services, but especially GPs – as we are the ones who have the vast majority of paediatric contact with the general population). This primary care training and funding should be in awareness, screening, identification, support and co-ordination of services that are more available in the areas that they are most needed. There are a range of ways this can be implemented – through awareness campaigns, professional development educational programs, but I believe the most essential component of improving identification of at-risk children and appropriate intervention, is incentivisation of change of practice at the GP level. This comes down to payment systems, such as item numbers and Practice Incentive Payments.

-Dr James Best, paediatric general practitioner

Australian Medical Association (NSW) Ltd

AMA House, Level 6, 69 Christie Street, St Leonards NSW 2065 | PO Box 121, St Leonards NSW 1590
t: 02 9439 8822 | f: 02 9438 3760 | e: enquiries@amansw.com.au | www.amansw.com.au | ABN 81 000 001 614

SUMMARY

Whilst medical practitioners recognise there is goodwill to improve paediatric care in NSW, poor resourcing and a general lack of support to implement new solutions to old problems means we continue to deal with issues that have been previously examined.

AMA (NSW) recommends:

1. The objective of the review should be to create the best possible paediatric services in NSW, not to simply respond to a critical incident or issues.
2. Whilst AMA (NSW) recognises the challenges of providing paediatric care at the LHD level, we do not support a centralised model. LHDs need greater resourcing to provide paediatric care. Additional funding is also needed to see the benefits of the hub and spoke model, which would allow for care to be provided to patients closer to home and alleviate the demand on services from specialist children's hospitals.
3. Paediatrics provides an important opportunity to seek genuine and meaningful integration of primary care and hospital-based services. It is important that such integration is supported with appropriate funding and recognition of the roles and responsibilities.
4. Wait times from referral to access of services should be reduced to allow for earlier interventions for children with developmental delays to improve their health outcomes.
5. Greater coordination between the NDIS and Medicare is needed, and funding for support services for children with developmental delays should be easier to access for families.
6. Funding and support for child and adolescent mental health services should be commensurate with the increasing prevalence of mental health issues in this demographic, particularly for patients aged 12-24.
7. Hospitals should be adequately resourced to provide dedicated paediatric mental health beds.
8. Admitting procedures for paediatric mental health patients be streamlined to allow timelier access to care.
9. Psychiatry workforce shortages be addressed; with a focus on increasing the number of child psychiatrists.
10. Expansion of the paediatric primary care workforce is needed to improve screening and identification. This includes general practitioners, as well as early childhood health nurses, midwives, practice nurses, remote access nurses and Aboriginal Medical Services.
11. Funding and training in awareness, screening, identification, support and co-ordination of services is central to improving access and early intervention.

Yours sincerely,



Dr Kean-Seng Lim
President, AMA (NSW)

Australian Medical Association (NSW) Ltd

AMA House, Level 6, 69 Christie Street, St Leonards NSW 2065 | PO Box 121, St Leonards NSW 1590
t: 02 9439 8822 | f: 02 9438 3760 | e: enquiries@amansw.com.au | www.amansw.com.au | ABN 81 000 001 614