Supplementary questions: Inverell Health Forum

1. Has the Rural Health Work Incentive scheme been used effectively in your region.

- It's been used and appreciated and it's always good to see more money for the health care workers of any description.
- In reality the qualification to be paid the incentive is limiting from DOH and then with LHD depends on the 'hard to fill 'or 'critical 'positions on the amount received. Eg in Inverell nurses that qualified for the retention payment…after tax received around $2500 and if they left within 18 months they have to repay it. It's therefore more advantageous for them to become an agency nurse and gain the higher rate of pay.
- It's disappointing that we are going down the destructive path with contract Nurses that we now have with Locums.

2. Your submission highlights the challenges when Locum healthcare professionals are placed in Inverell(p4)…

a. Expand on your concerns about the Locum model supporting gaps in the healthcare workforce in regional communities.

- The inequality of a Locum (who is often inexperienced) working alongside a local permanent and dependable General Practitioner who attends the Hospital on call is very evident and disheartening. A Locum on $4000 with no accountability and a local Dr tying up after they have gone receiving $1000 or even less depending on the number of patients.
- The Auction system that occurs with Locums means that 'hard to fill 'staffing gaps in a under resourced location is left to the last minute and the Locum is encouraged by the Agency to wait for a higher price to be offered before accepting. This can mean a doubling of from $2000 to $4000 per a day. The LHD then has to accept.. to keep the service required at this huge impost. The Agency also gets 10% to 15% so it's in their interest to keep the price higher.`
- Locums lack of local knowledge on Hospital procedures causes problems. Patients have been admitted from ED into the Hospital with no medical plan or organisation of treatment or tests performed and have left it to the Dr on the orphan roster when they present in the morning. This Dr generally also has a fully booked surgery. Many Doctors find this unworkable and now subsequently refuse to attend the Hospital.
- Lack of Accountability and responsibility has led to local VMOs having to assume the work the Locums don't attend to and then the VMO can be liable for what should have been done by the Locum. (Eg See insert of a letter below sent to Hospital 12/12/23 as further explanation)

Insert in italics

- *I would like to bring to your attention some important matters. I'd like to express my deep concerns about the safety and efficacy of working with the Emergency Department (ED) team. It appears that there is a lack of orientation to ED Doctor responsibilities, patient safety, and teamwork, making it unsafe for any ward doctor to continue as a VMO (Visiting Medical Officer) in hospital ward in this setting.*
- *In my capacity as a GP in Inverell, I believe the community in Inverell deserves the best care from the Inverell Hospital's Emergency Department. However, several incidents have compelled me to reconsider my involvement:*
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- *Here are a few recent examples I'd like to highlight, but there are numerous observations I've made since the start of my tenure in the hospital ward.*
- *Despite explicit instructions for Emergency Department (ED) doctors not to contact me past midnight for non-urgent matters, I continue to receive calls at 4:30 am. Patient handovers arrive through messages, often with photos of discharge summaries lacking accuracy and critical medical histories. A structured handover protocol is imperative, as ED doctors should not transfer patients to the ward without ruling out serious life-threatening conditions and providing a comprehensive handover.*
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- *The ED doctors consistently neglect to record medication details in Medchart or utilize old health summaries from the GP clinic. In one instance, a patient with [redacted], just three weeks post-admission in JHH, received incorrect medications due to them using an old medication chart rather than the JHH discharge medications. Despite the doctor's awareness of that admission, the patient was left without anticoagulants, posing a significant safety risk.*
- *A patient admitted with a [redacted] and receiving oxygen was not subjected to a requested chest X-ray (CXR) by the ED doctor, a critical omission. This led to the delayed identification of large pneumothorax 2 days later, a life-threatening condition. When the CXR findings were presented to the subsequent ED doctor by radiographer, they irresponsibly advised applying oxygen and monitoring oxygen saturation without even seeing the patient, and left the patient on the ward and didn't transfer the patient back to ED to be further assessed and then transferred out for specialist care and said it is not their responsibility. I had requested CXR on my first visit in the ward and the nurse informed that radiographer declined to take CXR as they believed he was outpatient causing a further delay in diagnosis. Fortunately, next morning CXR was performed for that patient. The CXR should have been done on presentation to ED with shortness of breath/respiratory distress.*

- *- A nurse urgently called me at 7 am on a Sunday, despite me not being on-call, regarding a patient's discharge schedule. The urgency turned out to be about the patient leaving against medical advice, necessitating an immediate review on that Sunday morning*
- *- A patient from [redacted] was admitted to my service without prior communication or permission. The lack of handover left me unaware of the treatment plan, highlighting a critical breakdown in communication and patient management.*
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- *Despite all above, I attempted to cover for my colleagues and filled in for shifts beyond my on-call duties. However, the strain of dealing with these issues has adversely impacted my mental well-being. I find it untenable to continue working with the unsafe ED team. I have decided to take an extended leave, hoping the hospital authority addresses these issues promptly for the sake of patient safety and community well-being. To ensure the well-being of the Inverell population, I, as a community-based GP, am committed to collaborating with the hospital consistently to enhance the safety of both patients and the community.*
- *Please let us know once these issues are dealt with so I can continue to work on the orphan roster.*
- Locums are unfamiliar with the Hospital routines and what needs to be admitted and treated locally and what needs to be arranged for transfer. There have been instances of everyone presenting at the Hospital being admitted as an in patient and another instance of everyone presenting being sent to Armidale because there was no knowledge of processes or services available in Inverell.

- This is seen as an opportunity for some (The lucky dip) unfellowed Doctors to take Locum positions and be paid high amounts. Thinking that they are up to the task, with some walking out due to the business of the Hospital.

- Some possible Solutions we see

  - Adjust the Taxation system to provide relief for any Dr moving to critical needs environments and scale to suit on severity of need… not always location but genuine need. Eg in a critical need area a Dr in any practice in that area claims a 30% rebate due to being prepared to serve that community as a permanent GP.
  - Capping the amount paid to Locums per site. This would need to be across all states or they will just migrate to where the money is flowing. This now applies to contract nurses and needs to be arrested or similar problems will occur. Most nurses now are going to contract purely for the extra money… Raising the rate of permanent nurse pay to match would stop this.
  - Centralise the Locum system with a standard pay rate, make contract requirements to work in various locations including rural, regional and remote locations on rotation. Award a standard pay rate, with set bonuses for rural, regional and remote locations for locums and abolish the current bidding system and choice of city and coastal appointments.
  - Push for more Australian students to go into medicine and incentivise Rural Generalist Practitioners who chose Remote rural regional areas. No HECS debt for Rural Remote Regional positions accepted for 5 year placements on a sliding scale of need. Make more university places available for those wanting to work in rural, regional and remote areas, enough students wanting to study but limited by places available.
  - There is so much wastage on 'by pass 'due to poor staffing management and inability to perform necessary operations …. even life saving activities. Multi skilling nurses to be able to fill Theatre, Dialysis, Maternity and ED and pay them well…according to their versatility. Could there be an extra post grad year where they do 3 months in ED, 3 months in Maternity, 6 months in surgical..? Then be paid accordingly for such qualifications? Provide additional supported training to upskill at no cost in return for contract agreements,
  - Lastly and most importantly showing simple kindness and respect for each other. So many leave the profession due to feeling undervalued, under appreciated, ostracised and bullied. This should be simple but I believe it's a huge issue. Even those in large referral hospitals treating Medical staff in smaller hospitals as lesser because they are not permitted to carry out what is needed due to restricting regulations. This often leads to serious risk in delay for the patient as a means of protecting the hospital from any potential litigation risk? Death is explainable somehow. Training on how to show respect is absolutely needed along with independent reporting. Hospital management culture needs to be more like private enterprise and less like the military?? Mutual respect not fear of supervisors. Negotiable flexible contracts which happen in the real world workforce but seemingly not in Hospitals.
  - Committees with teeth working with management should be able to help with this.