Submission
No 63

THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO THE DELIVERY OF SPECIFIC HEALTH SERVICES AND SPECIALIST CARE IN REMOTE, RURAL AND REGIONAL NSW

Organisation: Rural Doctors Association of NSW

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The Select Committee on Remote, Rural and Regional Health Inquiry into the progress of and issues relating to the implementation of Portfolio Committee No. 2 recommendations relating to health outcomes and access to health and hospital services

Submission on behalf of the
Rural Doctors Association of New South Wales (RDA NSW)

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The RDANSW is a member organisation representing rural doctors and the health of rural communities. Our members provide care in rural hospitals and as GPs in rural towns. We are well placed to understand the challenges of providing health care in regional and remote NSW.

Introduction:
The RDA NSW provided a submission to the previous inquiry conducted by The Select Committee on Remote, Rural and Regional Health into the implementation of Portfolio Committee No. 2 recommendations specifically relating to workforce issues, workplace culture and funding considerations for remote, rural, and regional health. Refer Submission No.49.

The RDA NSW thanks The Select Committee for the opportunity to provide a submission into the progress of and issues relating to the implementation of Portfolio Committee No. 2 recommendations relating to health outcomes and access to health and hospital services that was self-referred on 9 February 2024.

To date it appears too soon to see if there has been an impact on the delivery of specific health services and specialist care in remote, rural, and regional New South Wales. Any changes to policy, or to relevant procedures have not been seen on a day-to-day basis by many on the ground.

There continues to be significant challenges with management, including in the way that managers and GP proceduralist interact in the health districts. Although we do hear of some positive interactions, increasingly the RDA NSW is being contacted by rural doctors who are not having the same experience and have left, or are very close to resigning.

A new Industrial Award that reflects the scope that Rural Generalists with advanced skills provide needs to be developed to improve process of recruitment and retainment in rural hospitals. The current Awards in place are not fit for purpose.

Below is feedback that members of the RDA NSW have provided to the association regarding the impact of the recommendations implemented so far.

1)The delivery of specific health services and specialist care in remote, rural and regional New South Wales, including:

a) Maternity services, obstetrics and paediatrics (including Recommendations 19, 20, 26 and 27)

Any reviews undertaken so far by LHDs that have rural hospitals, do not appear to include genuine engagement with GP VMOs who, in many of these hospitals, provide procedural services such as: Obstetrics & Anaesthetics. More & more often the RDA NSW is being contacted by GP VMOs stating that:

- Specialist Obstetricians and Anaesthetists are preferred by the LHD to provide the services
- Specialist Obstetricians and Anaesthetists are more highly valued by LHDs and remunerated at higher rates for the same work at the same hospital e.g. $3000/day for O&G Consultant who cannot care for neonates, over local the

GP/Obstetrician who is embedded in the community and trained to provide safe, site specific, holistic care for mother and baby
- GP VMOs are not consulted when reviewing and updating service delivery plans, resulting in plans that are not contextually appropriate for rural hospitals
- Lack of supportive shared upskilling opportunities for rural GP VMOs and midwives, who periodically need higher volumes to maintain their procedural skills
- Inadequate collaboration or support from Specialist referral centres to smaller rural hospitals when a high-risk patient requires specialist input or transfer
- Services are being reduced and downgraded as GP VMOs are not supported by Administrators to control their own local recruitment and succession planning. Requests to offer supported 2-doctors-on-call arrangements, which would allow newly trained obstetric GP trainees to work in a town with an established experienced GP Obstetrician, are often rejected. This has perpetuated an unattractive, unsupported perception of training in rural obstetrics, controlled by administrators or consultant specialists with no appreciation for the challenges rural hospitals face
- Several maternity services in NSW are one doctor away from by-pass or collapse resulting in unattractive workloads, GP VMO burn-out and higher expenditure on locums e.g. Moree, Lithgow, Forbes, Gunnedah, Kempsey, Cootamundra
- Lack of a state-wide coordinated data collection and distribution system that identifies existing units requiring workforce support, and holds power to mobilise resources, rather than mobilising patients sometimes hundreds of kms away (which is more costly and more dangerous).

b) Patient transport and paramedicine (including Recommendations 3, 28 and 29)

Further work and consultation with local hospitals is required to ensure that appropriate patient care is provided. As resources such as VMOs in rural hospitals reduce due to the workforce shortage, opportunities to improve efficiency need to be maximised.

E.g. Patients who are violent or mentally unwell that require support and services provided at a larger hospital need to be transported directly to the most appropriate hospital first, rather than the closest hospital first, only to be assessed by the staff requiring a transfer.

Currently the transport of patients directly to the most appropriate service is inconsistent. Admission to rural hospital without the appropriate facilities can be draining on local hospital resources and there is a considerable amount of paperwork and time required to facilitate each process. Earlier assessment and consultation with staff at the hospitals, prior to the transfer of care, in many cases would allow the determination of the most appropriate facility, provide a more effective, efficient use of resources, and allow earlier appropriate care and services to be provided to the patient.

c) Indigenous health services (including Recommendations 23, 31, 32, 33, 34, 35 and 43)

d) Mental health services, and drug and alcohol services (including Recommendation 11)

e) Aged care and palliative care (including Recommendations 18, 23 and 24)

f) Cancer care and oncology (including Recommendation 21 and 30)

g) Other specialist care and allied health services, as they pertain to the Portfolio Committee No. 2 recommendations (including Recommendations 5, 10, 30, 42, 43, 44)

Outreach services provided by VMO specialists in some rural towns continue to reduce due to lack of support from management. e.g. A GP VMO in Scone (HNELHD) who regularly travels to Coonabarabran in Western NSW LHD (WNSWLHD) to provide scope services to local patients has recently been notified that travel reimbursement from the WNSWLHD for his travel expenses will end soon. Originally the VMO was given 1 months' notice, however the VMO was able to negotiate this to be extended until 30 June 2024. The VMO has been providing the services in Coonabarabran for number of years, but more recently the LHD has reduced the administration support provided to the VMO, making it more difficult for the VMO to carry out the previous number of procedures. A request for a basic IT equipment such as a printer has continued to not be provided for use by the VMO when providing the outreach service to assist with the efficiency of processing patient information. An updated Service Plan has not been provided to demonstrate what the LHD plans to do to replace the services that have been provided locally should the VMO not be able to financially justify continuing to provide the outreach service to Coonabarabran.

The local GP VMOs in Coonabarabran who refer patients to the service are very concerned about the negative impact that this will have on patients if the scope services aren't provided locally, forcing patients to travel out of town instead to regional cities such as Dubbo or Tamworth.

In Cootamundra, issues with administration have led to loss of nurses, including senior nursing staff and local GP VMOs with procedural skills, which is impacting on the retention and attraction of more experienced doctors and nurses. Patients and their families are being greatly impacted by the reduced quality of care available and increased need for the hospital to transfer patients to Wagga Wagga Base Hospital. Specialist surgical services have been impacted due to the resignation of GP VMO Anaesthetists and GP VMO Obstetricians, and loss of experienced staff involved in organising theatre lists.

The introduction of new, increased requirements when submitting a Referral For Admissions (RFA) at rural hospitals has also been raised as an additional burden to doctors providing an efficient service to patients and delaying timely clinical care due administration processes. This can lead to dangerous situations where non-clinical staff are challenging and, in some cases, overruling medical officers.

Allied Health

Allied health services also appear to face the challenges with LHDs prioritising virtual care, or hybrid models of care (mix of in-person & virtual care) being offered to patients, rather than focussing on working on recruitment and retention of in-person service providers.

2) Any updates or further observations relating to the progress of implementing Portfolio Committee No. 2 recommendations relating to workforce issues, workplace culture and funding issues, as per the Select Committee on Remote, Rural and Regional Health's previous inquiry.

Regarding recommendation 14, there has been no change to date regarding NSW Health funding Dermatology training positions in regional or rural NSW hospitals.

Although there has been an increase in rurally located trainees in NSW this year, this has occurred as a result of the *Commonwealth Government's Specialist Training Program* funding. Unfortunately these registrars are rurally located without public hospital access or exposure and are also isolated from their peers as a result.

Workforce issues are still a priority with high usage of locum doctors and nurses being used even though they are more expensive, don't provide the same level of continuity of care, unnecessary referrals and requests, high rates paid for locum's accommodation & vehicle expenses which could be invested in utilising local doctors and staff.

An increasing number of members are reporting that workplace culture is deteriorating in many hospitals due to increasing staff who can't take time off, inexperienced staff needing to be trained or covered for, stress, lack of effective communication, lack of engagement.

Funding for a Human Factors Training (HFT) position in Northern NSW was not renewed for a contract position that finished in January 2024 even though there was evidence to support that it had positively impacted retention of staff in the LHD. Interest in providing HFT in more LHDs has been positive to help reduce the number of deaths and incidents related to non-technical skill errors. Delivery of face-to-face HFT in more hospitals to needs to be implemented as a priority.

Medical Staff Councils (MSCs) in many rural areas are not functioning properly and this is impacting on many issues not being raised and handled appropriately. More focus on the importance of MSC meetings and having processes in place for genuine consultation and engagement between management and clinicians would avoid the unnecessary escalation of many issues and improve retention and attraction rates of staff, including VMOs.

Expansion of the Murrumbidgee Single Employer Model has been occurring which is positive. Members report that they are interested in learning more about the Single employer model. Some members, including practices and junior doctors weren't in the position to participate this year, but are keen to be involved in 2025. Issues raised by members include lack of understanding about funding and concerns about contracts, and uncertainty about the financial impact on private practice. These concerns have been raised with the Regional Health Division.

Summary

The RDA NSW believe that to date, since the recommendations have been made, that no positive changes have been identified. Attitudes from management, resistance, and lack of engagement with Visiting Medical Officers (VMOs) in service planning continue to be raised as the biggest issues. VMOs are instrumental in delivering procedural services, including Obstetrics, in many rural towns. If management is not inclusive, people become disengaged.

Although GP Obstetrics is usually in good standing where there are good staffing levels, there is still a lot of division between GP Obstetricians and Non-GP Obstetricians. The flow on effect of loss of Obstetric services cannot be overstated and leads to loss of anaesthetic services and surgical services provided locally.

The RDA NSW suggest that there needs to be a focus on better GP procedural representation at the LHD in managerial positions which would help improve the understanding of the skills and scope that for example, the local GP Obstetrician VMO can provide, and development of Service Plans that better reflect the capabilities at the site.

Independent of the results from this inquiry, management styles need to be addressed to resolve conflicts before they escalate to the point that rural services are downgraded or closed.

Dr Rachel Christmas
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