NSW Parliament Portfolio Committee No.2-Health
Parliament House
Macquarie Street
Sydney NSW 2000

19 April 2021

Dear Committee,

RE: Response to Supplementary Questions- Inquiry into Health Outcomes and Access to Health and Hospital Services in Rural, Regional and remote NSW

Further to attendance at the abovementioned inquiry hearing on Friday 19 March 2021, please find below my answers to the Supplementary Questions asked by the Committee.

Q.1a) In your submission you talked about the continual friction between hospital staff involved in patient care and various layers of the New South Wales health administration. Can you give us some examples of this?

Answer:
We point out that the examples we give are a small sample of the complaints we have received over time. We wish to emphasise that this litany of complaints is evidence of a wider dysfunction in administrative understanding and decision-making. The appearance is one of systemic problems and some significant issues with organisational culture. This will not be solved by trying to fix things piecemeal on a hospital-by-hospital basis.

Continual budget cuts or the need to adhere to a set budget is impacting on decisions made by hospitals that can have negative impacts in other areas. E.g. Casualisation of nursing staff causes loss of experienced staff as this basis of employment can impact their ability to settle in a town due to not being able to purchase a house.

LHDs can change a scope of practice significantly without community consultation as well as making subjective assessment on the degree of impact of these changes. In many cases it would appear these assessments are about the impact on the health service, not the consumers. Although normally a great deal of community consultation would happen, in some LHDs there is a very top-down impact statement saying how this is how it is going to be. Where services such as pathology are reduced to office hours, the impacts are felt in the different areas of the hospital. E.g. Gunnedah & Macksville Hospitals have lost their after-hours pathology which impacts on emergency caesareans not being able to be done, affects patient flow and decision making in the ED. VMOs and other hospital staff are then required to work under stressful work conditions.

Lack of understanding of different contract types and the benefits to communities such as the Rural Doctors Settlement Package (RDSP) Fee-for-Service contracts that many GP Visiting Medical Officers currently work under is causing friction. Since the RDSP was negotiated in 1987/88, NSW Health has continued to invest less time and money into training the VMOs employed on these contracts and the V-Money checkers who process accounts. Lack of investment and training people in the related processes leads to incorrect billing or incorrect item numbers being rejected. Over time, the frustration and continued battle for appropriate remuneration leads to the VMO resigning which in most cases adds to the workload of their colleagues who remain.
Many incidents are not reported in Incident Management System (IIMS) as GP VMOs in busy EDs do not have the time and resources to report each individual issue. In cases where IIMS is used by VMOs, VMOs report that the incident is swept under the carpet or leads to other negative experiences such as bullying, cancelled shifts, termination of contracts or AHPRA notifications.

It has been reported that there are apparent demarcation disputes that stop Inpatient Management (IPM) being accessed by VMOs and nurses to make even basic changes after hours. This impacts After-Hours doctors and nurses as they cannot load patients onto the electronic inpatient system, which is now even more pertinent as eMeds needs the patient to be loaded in order for GP VMOs to do their work. It usually takes 20-30 minutes waiting for a clerk in another hospital to load the patient. Nurses at the local level are expected to complete a form, fax it to the bigger town, and then ring to alert the clerk in the bigger town. RDA NSW has been advised by the eHealth team that: "Clinicians can request access to the PAS through their local IT department or SWSD. There will be training available in the use of this application to ensure staff are equip to admit or transfer patients after hours in a timely manner." However the RDA NSW has not been advised that this issue has been resolved. Another product of this for hospital staff is that they do not get sticky labels unless admin is working and this really slows staff down when doing charts, forms, requests, etc.

Some doctors have reported that nursing staff and administrative staff seem to be obstructive and preventing doctors from doing appropriate surgical procedures on the pretext of not enough nurses or inappropriate procedures.
E.g.: Dr was told they should not do an appendicectomy on an otherwise healthy young man. The Dr felt that transfer to the base was unnecessary and delayed treatment at added expense. There is poor communications regarding staffing levels. The Dr was been told by admin that Dr can't operate because there are not enough nurses for theatre but then told by nurses in the hospital that they were available.

Another example is all doctors in a hospital who complained that they were being notified very late about admissions of their patients and being scolded by nurses for not coming to see them.
In particular, a VMO had multiple IIMS made about them not attending to their patients but had not been told they were in hospital. This resulted in the VMO being investigated by AHPRA.
The hospital "GP" clinic is being staffed by unqualified OTDs with some undesirable results. The hospital seems to be using it as another GP clinic rather than as a way of dealing with triage 4's and 5's.

GP Registrars are resigning or relocating due to inability to use Advanced Skills training in LHD due to needing supervision but are allowed to in a different LHD without the same level of supervision being required.

Roster changes are made without adequate notice or discussion with VMOs.

A Health Service Manager in Hunter New England LHD accused the GP VMO of immunising staff health patients and billing them through Medicare as fraudulent. The HSM approached the receptionist where the GP VMO worked prior to discussing the concern with the GP VMO first. The GP VMO wrote to the HSM to raise the issue and provide reasoning of why billing Medicare was appropriate including:

- The Doctor is responsible for all the activity in Multipurpose Service.
- The doctor has to check the dose / vial of the flu injection being given to the patient ("Seen by Dr X") and make sure it is the right dose for the right patient.
- The patients, including staff patients, are instructed by the nurse to wait for 15 minutes in the Dr's waiting room to be monitored for complications or reactions. At that time the patient is still the Dr's responsibility.
- The Dr then will go back in at the end of the day and do all the sign offs for the patients she was responsible for that day.
- Until the MPS has a clinical practitioner for Staff Health the doctor will continue to look after the staff in the institution.

During Hospital Redevelopments, many GP VMO's contact the RDA NSW due to feeling that the local doctors are not being consulted adequately in the planning process. This is evidenced in Southern NSW and Hunter New England.

Directors of Medical Services in NSW have advised that they find it difficult to get any changes done in funding allocation and supply of beds in the hospital due to issues with NSW Health Administrators.

Q.1.b) Are there LHDs where this is worse?

Answer:
Hunter New England, Murrumbidgee, Mid North Coast

Q.2. Do you think that rural hospitals rely too much on locums?

Answer:
Yes. There appears to be no overall strategy to replace resigning GP VMO's. The costing analysis of this appears to be flawed.

Q.3. You have stated in your submission *"We are very aware of many doctors and nurses who have resigned from hospital work over the years due to ongoing difficulties in obtaining support and*

preserving facilities to provide good comprehensive care in rural hospitals" (pg.1). Can you please specify which LHD this is occurring in?

Answer: Hunter New England, Northern NSW, Murrumbidgee, Southern NSW, Western NSW.
Some examples of towns that we are aware of this occurring in within the past couple of years include Inverell- Doctor had worked for several years in the hospital and General Practice. They finally resigned and relocated interstate due to ongoing unresolved issues and inability to obtain support.

Bega- Hospital was redeveloped to South East Regional Hospital and VMO contracts that had been in place were not grandfathered after requests from VMO to negotiate the new contracts with a rural classification. Facility continues to be understaffed and underutilised.

West Wyalong- VMO resigned and relocated due to not being supported while working in the town. The doctor experienced many ongoing issues and was quite frustrated with lack of support to leading to Emergency Department being put on COSOPS due to not advertising for a locum over a Christmas period.

Parkes- Ongoing lack of support and increasing burden from eMR, eMeds, complexity of patient conditions, growing number of policies, guidelines. Doctors reported finding hospital work increasingly burdensome and time consuming.

Urbenville- (small single doctor town) is in danger of losing medical service due to ongoing failure to respond to the doctor's requests for necessary changes and support. Even minor issues seem to be difficult to resolve.

Dunedoo- A good Hospital Services Manager (HSM) resigned and was lost from NSW Health after continued lack of support when identifying staffing, organisational and supply issues at the hospital.

Q.4. You also said in your submission: *"It is our opinion that there is a misunderstanding of safety outcomes and costs in rural hospitals and that too many decisions are driven by specialist colleges with little understanding of how to deal with things under local conditions."* Can you please clarify if this means that there are know safety concerns and if so what are they?

Answer:
This comment does not apply to specific safety concerns. Rather the apparent assumption that health care in rural hospitals is less safe than in large hospitals under specialist care and that outcomes are worse, despite lack of evidence that this is so. This attitude leads to loss of confidence in local care and inappropriate decisions to withdraw support for care in rural hospitals. The overall result is worse outcomes at higher cost. There is a reduction in services available locally and both community and doctors are dissatisfied. This can in turn lead to difficulty in retaining doctors.
If anything, our concerns would be around poor outcomes in tertiary hospitals compared to smaller rural units.

Q.5 Are you aware of any examples when Administration of an LHD is making clinical decisions?

Answer:
Yes, an example of this is a VMO with a long and unblemished record of providing GP, anaesthetic and endoscopy services in WNSW and HNELHDs. The VMO does Colonoscopies once a month and previously used to do the sedation themself up until 3 years ago then the LHD decided it wasn't safe enough. The provision of Anaesthetists has been haphazard since.

In 2019/20 the VMO experienced a litany of problems relating to their endoscopy service in a rural town. The problems included but are not limited to: -

- Lack of administrative support
- Inconsistent decisions by GP anaesthetists relating to which patients are allowed on to the VMO's lists. In August 2020 the Anaesthetist crossed 5 people off the list
- Poor communication with the VMO, Referring GPs and patients with respect to waiting times and changes to lists
- Poor patient care secondary to administrative bungles
- In 2020 a patient was coming from Bathurst who was an urgent care. The VMO did the booked procedures between 7:50am-10:30am. The VMO finished earlier than planned, which was expected to be Noon. The urgent case however wasn't added to Dr VMO's list
- The VMO is having trouble with patients requiring treatment <30 days being prioritised, e.g. new PR bleeding, heart burn symptoms
- The VMO has complained to the Hospital Manager as patients are now being forced to drive to an extra 5hr round trip for treatment in some cases
- The VMO has started getting emails from the booking clerk requesting him to justify his clinical input

  E.g. In September 2020, one of the latest interventions, actioned by a hospital Admissions Clerk, escalated the problems to another level, going to the heart of clinical decision-making. What made the email of even greater concern is that the LHD has made it clear that the VMO's consultation lists are a private matter. Accordingly, these email requests seeking clinical information are questionable in their intent as well as their legality. On the one hand, the LHD does not consider the VMO pre-operative consultations their responsibility, yet on the other hand, the LHD seeks the information from these consultations to interrogate the VMO about the VMO's clinical decision making.

In some hospitals, allocation of priority for surgery is made according to administrative criteria despite recommendations by clinicians. This has led, for example, to undesirable delays in cancer surgery.

Q.6. In addition to what is contained in your submission and evidence provided at the public hearing, do you have any further comments regarding the current provision of palliative medicine, nursing and care in rural, regional and remote New South Wales?

Answer:
In many rural towns the GP VMO model of care provides the patients with continuity of care and is the most cost efficient. Most rural GPs already provide palliative care in the community. In most cases this is possible with the skills available. Provision and quality of palliative care is dependent on the willingness and capacity of the local services. There does not appear to be consistent support across the state and the level of service can be quite variable.
On occasion, the ability to get advice form a palliative care physician may prevent the need for transfer to hospital. The ability for rural doctors and nursing home staff to contact a palliative care physician 24 hours a day, for example for advice with an acute deterioration, may also enable patients to be managed locally.

Q.7. In addition to what is contained in your submission and evidence provided at the public hearing, do you have any further comments regarding ways to improve both the access and availability of palliative medicine, nursing and care in rural, regional and remote New South Wales?

Answer:
More needs to be done to improve the communication between LHD's and GP VMOs in Service Planning in hospitals. E.g. Population growth and in specific demographics is not properly taken into account when planning hospital redevelopments.

With the aging population and increasing burden of chronic disease the palliative phase of care is often longer. As well, the number of people requiring palliative care is increasing. There is a need for an increased number of beds for palliative care in rural hospitals and aged care.

Dying at home is often a quite reasonable wish for patients. Additional resources to facilitate family care at home would reduce the pressure on hospital care. Where a palliative care team is available to support home care this can often be achieved. Appropriately trained palliative care nurses, supported by the GP, with telehealth specialist palliative care input where needed, can provide effective home care in this phase of life.

Yours sincerely,

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