INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NEW SOUTH WALES

RESPONSES TO SUPPLEMENTARY QUESTIONS

Australian Salaried Medical Officers' Federation (NSW)

1. *ASMOF believes that the NSW Government must immediately invest in Rural, regional and remote health to support the short-term and long-term viability of Rural, regional and remote hospitals and ensure patient care is aligned with community and medical standards. What is the level of investment shortfall you currently see with the funding?*

Calculating a figure on the investment shortfall is beyond the capacity and resources of ASMOF NSW. The Ministry of Health and LHD's need to undertake the relevant costings by looking at the areas that we have shown are underfunded and under-resourced.

NSW Health must immediately focus on capacity building within the rural doctor workforce. More full-time equivalent Staff Specialist positions are needed across many rural LHDs and reflect only a small component of the investment that is needed in rural health. In addition, NSW Health needs to properly incentivise employment in rural hospitals to recruit and retain doctors, fund dedicated pathways for medical graduates and support equity of access to education.

As we noted in our submission, the way funding is delivered in rural health is connected to the investment shortfall. A one-size fits all approach to funding is inadequate for rural areas because metro-centric protocols are often unsuitable for smaller hospitals and health service. The mechanism of activity-based-funding (ABF) short-changes rural communities because many rural hospitals are marginally viable under ABF. NSW Health needs to recognise that ABF does not suit many rural sites and ensure there is adequate funding for all rural hospitals through other suitable funding mechanisms.

2. *ASMOF has said that NSW Health needs to increase the provision of essential services. Can you please provide specific examples of a hospital that isn't providing an essential service?*

It is difficult to determine which hospitals are not providing an 'essential service' due to ambiguity over what is 'essential'. However, our members have raised concerns that rural

hospitals and facilities have less infrastructure to provide basic services, meaning rural doctors are unable to deliver the same standards of care to rural patients as those living in metropolitan NSW. This is reflected in the data that the proportion of people who reported the lack of a specialist nearby as a barrier to seeing one increased from 6.0% in major cities to 22% in regional areas to 58% in remote areas.[1]

There are major issues with accessing out-of-hours medical care in rural hospitals, with 39% of people in remote NSW reporting extreme difficulty compared with 17% in major cities.[2] Consultations with ASMOF members revealed that at Armidale Hospital, the Emergency Department do not have doctors on site, instead relying on telehealth. The issues that flow from having no doctors on site have been widely reported at Gulgong, Cobar and Tenterfield Hospitals.

At Coffs Harbour, ASMOF members reported that a range of essential specialities are not available. Doctors reported that there is no Neurologist, no Endocrinologist and no Infectious Disease Specialist. It is the largest hospitals outside Sydney and patients have to travel elsewhere to get to their treatment or specialist advice is sought via telehealth. For example, if patient is having a stroke, they will get urgent treatment via telehealth. Similarly, patients with Multiple Sclerosis have to travel to receive neurological treatment, and a patient having a thyroid crisis or diabetic crisis will have to travel to see an endocrinologist. However, this is not ideal for patients or staff.

At Bellingen and Macksville, the understaffing at the emergency department at Macksville is leading to after-hours doctors being pulled from Bellingen. This means that essential services not being provided sometimes between 6pm-10am at Bellingen.

Consultation with ASMOF members working at regional centres revealed that relatively simple services such as a cardiac pacemaker insertion cannot be performed, leading to the need to transfer patients to Sydney.

[1] AIHW 2018. Survey of Health Care: selected findings for rural and remote Australians.
[2] Bureau of Health Information. *The Insights Series – Healthcare in rural, regional and remote NSW*, Sydney (NSW); BHI; 2016.

3. *ASMOF wants to see rostering improvements. Can you please provide some examples on this?*

The need for safe, fair and equitable rosters is of fundamental importance to the wellbeing of doctors and the functioning rural hospitals. It is essential that NSW Health ensure that rosters conform to the Industrial Awards and NSW Ministry of Health policies. Further, rostering arrangements must be the product of meaningful consultation with doctors to ensure the safety and wellbeing of both staff and patients

ASMOF advocates for specific rostering improvements at a local level. There needs to be better education of rostering managers to ensure they provide best practice rostering which are compliant with Awards. Most of the rostering issues to do with unsafe hours relate to there not being enough trainee doctors to ensure safe hours.

At Armidale Hospital, doctors have reported that an inadequate staffing profile and poor rostering is leading to an unsafe work environment. ASMOF are now seeking for an additional CMO/Registrar level doctor to be engaged at the Armidale Emergency Department so that there are two CMOs and one SRMO rostered during their busiest 4pm-11pm period.

At Tamworth Hospital, some trainees in obstetrics and gynaecology reported to us that they were working 125 hours per fortnight. We need to see more training positions and more funded to enable greater employment. At Tamworth, we are now asking for a sixth Registrar to be employed.

As noted in our submission, ASMOF members at one regional hospital reported that hospital management purposively kept the roster concealed from the staff, so they did not know they were working solo until they arrived for their shift, because the staff would have pulled out if they knew due to the medicolegal risk. These rostering practices within rural hospitals are completely unacceptable and dangerous.

Rostering issues are endemic across rural health. We recommend that all rural hospitals undertake a transparent review of doctors working hours in consultation to improve rostering and ensure that doctors and patients are not placed at risk.

4. *Are you aware of doctors working unhealthy working hours and unsustainable overtime to provide care? Is there an area where this is particularly worse?*

Unsustainable overtime is unfortunately widespread in the medical profession. The Hospital Health Check surveyed 1332 doctors in training in NSW in 2020 and found that 44% believe their personal safety was at risk due to fatigue, and 49% of respondents worked more than five hours of un-rostered overtime in an average fortnight.[3]

ASMOF is currently managing live matters relating to doctors working unsustainable overtime at Tamworth Hospital, Maitland Hospital, Wagga Wagga Hospital, NETS service-Sydney Children's Hospital Network and Palliative Care Coffs Clinical Network.

Some specialties are particularly at risk of understaffing across the board. We highlight that Obstetrics and Gynaecology, Psychiatry and Emergency Medicine are areas where a complete staffing review desperately needs to be undertaken.

As noted in our submission, rural LHD's and hospital management often lack understanding of the requirement under the *Staff Specialist (State) Award* to provide office accommodation, administrative support, non-clinical time and support research. The failure to recognise what needs to be provided under employment entitlements contributes to excessive workloads and often results in doctors having to spend spending significant time on administrative duties that deprive rural communities of hands-on clinical work.

We also submitted that rural emergency doctors have additional tasks than metropolitan doctors because many patients have to be transferred. ASMOF members estimated this takes an extra 30-60 mins of a doctor's time because there are no inpatient teams completing documentation and medication charts, and no physios or nurse practitioners to do plastering/suturing/cannulation etc.

The cancelling of shifts in rural emergency departments have also resulted in doctors working unhealthy hours. One ASMOF member reported the cutting of a 1400-2400 shift at one regional hospital, which resulted in only one doctor working between 1800 and 2200 in a department that saw 3-4 patients arriving per hour. A member at another regional hospital

[3] https://www.amansw.com.au/wp-content/uploads/2020/09/HHC-2020-AMA-results_V2.pdf

reported that there are nights with no doctor and because the FACEM is on call, they are at risk of being expected to work 20-hour shifts, with 4 hours off before the next shift.

In addition, doctors have reported being unable to take sick leave, annual leave or Allocated Days Off (ADOs) because there is never adequate cover. Members mentioned that they did not feel comfortable about taking ADOs because their colleagues would then be required to do (often unpaid) overtime. Similarly, members reported immense difficulty in accessing sick leave and finding cover when they were sick, which is completely unacceptable in a pandemic. NSW Health must build a culture in rural LHD's that supports the taking of leave and sick days.

5. *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?*

Palliative care services in rural areas are chronically underfunded and understaffed.

We have consulted with members and identified a number of under-resourced areas. In the Coffs Harbour & Hunter region there is a lack of nursing staff, and at Dubbo and Wagga there are no palliative care specialists. At Maitland, where there is a growing population, there is only 1.8 FTE palliative care specialist, which is grossly inadequate.

Palliative care specialists are involved with patients across a range of departments, including ED, surgical patients, oncology, and chronic pain. They also work in the community and in home clinics. Home visits takes a lot longer but are an essential element of service delivery. In the words of one ASMOF member and palliative care specialist "We are only 1 person; we can't be everywhere and every site at the same time."

A lot of the assessments for funding are developed on a metropolitan basis and do not account for the extensive travel required to make home visits in rural areas. Overworked practitioners who are fatigued need to drive long distances in rural areas, which is a safety hazard.

An imminent issue identified by members is that the at the end of June the NSW State Government will stop funding Silverchain, who were funding to provide nursing packages end of life care to patients across NSW. Silverchain also provided a 24-hour helpline service

to patients. ASMOF is led to believe that this funding will be provided to LHDs and we are concerned that this may impact service provision in the area as the existing palliative care services do not have the resources or staffing to provide the same level of service, particularly after hours.

6. *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?*

The palliative care workforce needs to be significant expanded, both in terms of doctors and nurses. Palliative care services need to be resourced to adequately reflect the requirements of these services in rural areas, including travelling long distances for home visits. This will also allow for more in-patient beds in rural hospitals.

Whilst specialists are always needed and provide an essential education and training role, consideration needs to be given to innovative funding models that expand the palliative care workforce. This includes options such as upskilling Career Medical Officers and Senior Nurses and supporting General Practitioners with palliative medicine diplomas to do fractional palliative care work.

Members have informed ASMOF NSW that practitioners do not want to be a solo practitioner and it is an unfair burden on the employee. We submit that there should be zero solo practitioners in rural areas. NSW Health needs to fund more positions and encourage palliative care doctors to go to the bush, so there are at least 2 consultants employed at 1.0FTE.