Submission No 511

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

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14.1.21
The Hon Greg Donnelly MLC
Committee Chair
Parliament House
Macquarie Street
NSW

RE: Inquiry into health outcomes and access to health and hospital services in rural, regional and remote New South Wales

Dear Honourable Members,

I am writing as the head of the Acute General Surgical Unit at John Hunter Hospital (JHH), the major tertiary and teaching hospital in the Newcastle and Lake Macquarie region. I am also the head of the Oesophago-gastric Surgical Unit. I have been working in the area as a consultant surgeon since 2001. I have at other times worked overseas, and at teaching hospitals in Sydney and maintain that the HNELHD is under resourced.

Our referral base at JHH covers a large population, and a large geographic area. The JHH receives patients from around 30 smaller hospitals and provides tertiary care for 1.5 million people. These areas on the whole have older patients with higher rates of obesity and smoking, comorbidities and socioeconomic disadvantage. It includes a substantial number of Aboriginal patients. These medically complicated patients have increased risks of surgical diseases, including malignancies of the oesophagus, lung, colon, breast cancer, endometrium and diverticular disease, gallstone disease, reflux disease and so on. When they do present they are often sicker and more complicated to manage.

Whilst the John Hunter has expanded since I started here in 1994 as a trainee surgeon, it has at all times lagged behind the demands that even the Greater Newcastle community place on it. That it also caters to the remainder of the HNELHD, and is able to provide high quality care is a testament to the dedicated and hardworking staff. The redevelopment for the JHH is still years away, and almost certainly the need will have outgrown the planned hospital capacity by the time the new development is completed.

Our Medical Staff Council has provided a submission that describes how the strain of serving this population of patients whilst being under resourced has impacted the patient experience, and the staff.

I wish to add further to their document, focusing on the 2 areas in which I have expertise.

1. Acute general surgery (and trauma)
   JHH is the tertiary referral centre for trauma and complicated acute “general” surgical issues across northern NSW, as well as serving the needs of the local community. Over 50% of our surgical caseload is unplanned. As surgery has become more specialised, and patients have become more comorbid, surgeons in regional

centres have become less confident to manage conditions they once may have been prepared to deal with. Advanced laparoscopic and thoracoscopic surgery, interventional endoscopy (such as ERCP and stenting services) and interventional radiology are available in few centres. Thus many patients are transferred for procedures that previously may have been dealt with locally by other means. The need for high dependency post-operative after-care also limits the preparedness of surgeons to undertake emergency procedures in smaller hospitals where they do not have this facility.

When patients that require transfer to JHH for management of surgical conditions are referred, the ability to receive these patients in a timely fashion is often affected by:
-delays in transfer related to transport availability
-Delays in transfer related to ward bed availability
-inability to accept patient due to no ICU bed availability.

In addition the capacity of the JHH operating theatres and particularly ICU to cater for this influx of patients is often limited, meaning that elective cases get cancelled to cater for the urgent and semi-urgent caseload.
The alternative, which is to transfer patients to Sydney often deprives the patient of their local support network, as it takes them further from their families.
The stress on the system is particularly noticeable at Christmas and New Year or Easter periods where many regional hospitals have staff on leave or employ locums. Patients with relatively simple to manage conditions can end up transferred large distances because facilities are not maintained locally.
This occurs despite the population of many coastal regions swelling with holiday makers. Hospital administrations often see these times as opportunities to save money, but illness and injury does not recognise holiday periods and do not take a break. The period is often stressful for clinicians left trying to organise urgent care, either seeking transfer, or accepting care.
Our hospital is the busiest trauma centre in NSW, but has ongoing issues with staffing levels.

By comparison to Westmead, where 36 surgeons cover the acute general surgical and trauma roster, at John Hunter 15 surgeons provide this service, whilst also having separate on call at the local district hospital, and providing subspecialty cover.

2. Oesophagogastric surgery

Management of oesophageal and gastric surgery has become more specialised, resulting in better outcomes related to centralisation of services. While the JHH may fulfil the role of a tertiary referral centre for these cancers, the constant vigilance required to ensure that patients do not fall through the cracks of a complex multidisciplinary service is quite exhausting. As medical and radiation oncology

services are separate in Newcastle, being done at the Mater hospital or private hospitals, tracking and coordinating the path from diagnosis to aftercare is not well supported. We are in need of dedicated nurse consultants that help patients navigate through their cancer journey. Support services such as clinical nurse coordinators, dieticians, clerical, speech pathology and physiotherapy as well as imaging, medical and radiation oncologists and research coordinators are critical to the provision of optimal care for these patients, many of whom come from regional areas. The ongoing development of oncology services in regional centres has been of great benefit to many patients, but they , and local oncology services are overstretched with significant delays in treatment commencement. Telehealth is also important, but until recently has been not supported adequately.

The lack of ICU and HDU beds also affects these patients as operations may need to be rescheduled, and patients are discharged prematurely to the ward. Ward staff are excellent, but are caring for multiple patients of high medical complexity already, many of whom would meet HDU criteria in other institutions.

Operating time is limited due to inadequate operating space and unwillingness to allocate more time and resources to reduce operating lists so that non cancer work often overruns.

Work much of the time feels like a continuous juggling act. We spend so much time putting out spot fires, we can't instigate or develop meaningful changes.

Options at the moment such as rural outreach within the LHD are impossible due to lack of support and time.

Bariatric surgery is not supported in the public system, however our unit often has to cope with complications from fly in fly out surgeons who operate on self funded patients for bariatric procedures, but are not available to provide aftercare when things go wrong.

In summary,

Our services are under significant strain trying to provide high quality, patient centred care. The Sydney- centric and marginal seat political focus can be very frustrating to health care providers, and patients. The geography and work load of our LHD provides challenges that are not accounted for in state wide planning. The capacity of the local health service is severely strained and we feel the work that the LHD does should be adequately recognised and resourced.

Thank you for the opportunity to respond to the Inquiry