# Special Commission of Inquiry into Healthcare Funding

## Statement of Dr David Scott

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| **Occupation:** | Physician and Gastroenterologist Visiting Medical Officer and Chair of Medical Staff Council, Hunter New England Local Health District |

1. This statement made by me accurately sets out the evidence that I would be prepared, if necessary to give to the Special Commission of Inquiry into Healthcare Funding ("the Inquiry") as a witness. The statement is true to the best of my knowledge and belief.

2. It is provided in response to topics identified by the Inquiry in a letter to the Crown Solicitor's Office dated 14 August 2024 (**MOH.0010.0542.0001**), to the extent that such topics are relevant to my role, and to the Inquiry's letter to the Crown Solicitor's Office dated 22 August 2024 (**MOH.0010.0541.0001**).

## A. INTRODUCTION

3. I am a Physician and Gastroenterologist Visiting Medical Officer (**VMO**) and Chair of the Medical Staff Council (**MSC**) at Tamworth Rural Referral Hospital (**Tamworth Hospital**), Hunter New England Local Health District (**HNELHD**). A copy of my curriculum vita is at (**MOH.0010.0538.0001**).

4. In this role, I am responsible for the clinical care of my patients at Tamworth Hospital and the supervision and education of other health professionals, as well as chairing the MSC, which is the body for doctors employed by Tamworth Hospital, making representations on their behalf to various groups including to the Tamworth Hospital or HNELHD General Manager as required, or for example, to the recent Parliamentary Inquiry into health outcomes and access to health and hospital services in rural, regional and remote NSW.

5. I work at Tamworth Hospital, which is located relatively close to Armidale Rural Referral Hospital (**Armidale Hospita**l). The remaining HNELHD hospitals north of Tamworth and Armidale are District Hospitals and are generally run by a General Practitioner (**GP**) workforce. South of Tamworth and Armidale, we primarily interact with John Hunter Hospital and the Calvary Mater Hospital, both of which are located in Newcastle and are larger tertiary hospitals, as well as with Sydney hospitals in specific instances.

## B. BARRIERS AND OPPORTUNITIES IN DELIVERING INTEGRATED CARE

6. Rural hospitals operating across HNELHD are smaller and used to be run by local resident GPs but are increasingly dependent on virtual doctors or fly-in, fly-out (**FIFO**) locums. Likewise, Tamworth used to part of the smaller New England Area Health Service but is now part of the bigger HNELHD. In some ways, these two changes make delivering integrated care harder, as set out below.

**(i) GP workforce**

7. The number of GPs working at our rural and regional facilities and privately, is decreasing. Consequently, our smaller facilities are faced with staffing shortages and are becoming increasingly dependent on locums and Telehealth. This has an impact on Tamworth Hospital in a number of ways, including an increased presentation of patients to our EDs with lower levels of acuity. This is because a larger number of patients do not have immediate access to their community GP or have otherwise consulted with a GP virtually who is not aware of Tamworth Hospital's local capacity. Whilst attempts to relieve the pressure on EDs have been made with the introduction of Urgent Care Clinics intended to address patients with urgent but minor problems, there is still a large demand on our ED and there are long wait times for patients in lower triage categories.

8. Additionally, GPs working rurally have traditionally held a diverse range of skills. For example, a GP working in Gunnedah has the capability to drain chest tubes, insert breathing tubes and apply spinal or general anaesthetic for Caesarean section births. Over time, we are seeing fewer GPs with this extended scope of practice. Increasingly these higher acuity patients are being transferred to HNELHD's District Hospitals including Tamworth and Armidale, increasing ED presentations. Any efforts made to train, attract, and retain these rural specialist GPs would be cost effective. Payment structures may need to change to reward people with extended skills in areas of need.

9. Whilst Telehealth and the use of virtual services such as 'My Emergency Doctor' have been introduced to address workforce shortages in rural and regional facilities, and are an effective temporary solution, they are not an effective replacement of clinical staff working in our rural and remote facilities. This is because virtual services such as My Emergency Doctor are reliant upon the local nursing staff to assist patients use the service, while also manage competing priorities, resulting in an increased workload. For example, local nursing staff may be interrupted from treating other patients to facilitate the use of My Emergency Doctor by having to sit beside the patient utilising the service or examining them in front of the virtual doctor. Virtual doctors are also less familiar with the specific strengths and weaknesses of a particular location which may make their

advice inferior to that of a local doctor. Most doctors and nurses I have spoken to have mixed feelings about virtual medical services in smaller EDs, and very few would consider them comparable to traditional local services.

**(ii) centralisation of services, equipment and decision-making**

10. The centralisation of services and equipment at HNELHD has required Tamworth Hospital to increasingly refer its patients to John Hunter Hospital for care, increasing the workload of John Hunter Hospital, the need for transportation of staff, and further constraining bed capacity. Centralisation of services can facilitate integration and improved outcomes, such as through 'centres of excellence' and clear referral pathways, and there are examples of those in our District. However it can also make integration of care more difficult.

11. Whilst not all services can be performed at Tamworth Hospital, the centralisation of services to John Hunter Hospital, which is located at the fringe of HNELHD, further exacerbates transportation and bed capacity issues across the LHD. Patients wait in hospital for days for a bed at the destination hospital to become available. This would be unnecessary if services were decentralised and available locally. Some services are also very easily decentralised and do not require an excessive amount of specialised equipment or support. It has been my experience in Tamworth that starting a new service here such as pacemaker insertion or faecal transplantation, that already exists in Newcastle, has been more difficult than it should have been. If a decision is centrally made that a procedure is safe and cost effective to perform in Newcastle, Tamworth staff should not have to advocate to also offer the same service locally.

12. The centralisation of services and equipment in HNELHD to John Hunter Hospital and the Newcastle area more generally, also restricts Tamworth Hospital's ability to increase services locally. For example the first and second PET scanner for HNELHD are both located in Newcastle.

13. Decision-making is also increasingly occurring in Newcastle, with rural and regional facilities feeling left out when it comes to decision-making. Most members of the medical staff council believe increased local decision-making and short of that, more input into centrally made decisions, would improve the LHD's ability to attract and retain our workforce with the ability to make award and employment criteria adjustments to suit local facilities. I believe recruitment would improve if Tamworth Hospital could make

decisions about incentives and conditions locally, rather than having to seek and wait for district or state-wide decisions.

14. For example, I consider facility led recruitment campaigns will improve the likelihood of attracting staff interested in living and working at Tamworth. Recently a recruitment campaign was undertaken to recruit new anaesthetists to HNELHD. Two positions were advertised by HNELHD on behalf of all hospitals in the District. None of the applicants were interested in working at Tamworth Hospital. As a result, we are now advertising as a local institution, providing applicants with additional information relevant to our facility and directed to the type of person we hope will apply.

## C. SUPRA LHD SERVICES AND LINKING OF NETWORKS IN REGIONAL AND REMOTE AREAS WITH METROPOLITAN AREAS

15. My experience with access to state-wide supra LHD services have been positive. John Hunter Hospital conducts the majority of specialised services, but not all. For example, liver transplants occur solely at Royal Prince Alfred Hospital. I have not experienced any issue with getting access to supra-LHD services offered outside of HNELHD. The primary barriers to the transfer of services from rural and remote services to metropolitan areas is bed space and transportation. I have had minimal difficulty obtaining advice from colleagues at tertiary hospitals and find personal contacts at least as valuable as formal referral pathways.

16. Additionally, whilst geographically Tamworth Hospital is closer to John Hunter Hospital, there are no flights to Newcastle. Some patients do not mind driving if a suitable flight is not available, however sometimes it is more convenient to attend a facility in Sydney.

## D. ESTABLISHMENT OR CESSATION OF SERVICES

17. One of the issues in determining whether to establish services at a facility is a lack of data. It is difficult for executives to make these decisions when the information does not exist. The oncologist with a clinic only service at the hospital will have a waiting time, and so funding changes can be made based on that information. Whereas a neurologist who sees all their outpatients and conducts all their diagnostic and therapeutic procedures in the community, will not have a waiting time visible to the Tamworth Hospital or HNELHD. Accordingly, there is an absence of data to determine whether a neurologist or oncologist is required to service community needs.

## E. CLOSING THE GAP

18. Whether improved health outcomes for Aboriginal and Torres Strait Islander people has been achieved, is difficult to measure on the ground. Treating Aboriginal people is a large function of HNELHD, which has more Aboriginal residents than any other LHD. In my view, better integration between hospital and community services would assist in obtaining better health outcomes for Aboriginal people. This is because, in my experience, Aboriginal people present to hospital with profoundly preventable problems that could have been managed in the community. Additionally, in my experience Aboriginal people are more likely to prioritise local rather than distant treatments, preferring to stay 'on country' if at all possible. In these circumstances, the decentralisation of services would be preferable and more accessible to them, resulting in improved health outcomes.

## F. WORKFORCE

19. What attracts an employee is different to what retains them. Recruitment is dependent on marketing and market forces, whereas retention is more about the level of support the employee receives while working, and their satisfaction with their job and lifestyle. Because of workforce shortages and the need to recruit staff to address those shortages, there is typically less focus on initiatives to retain staff. I am aware of a recent appointment that lasted less than a year. There may have been multiple reasons for the resignation, but two appeared to be that the clinical demands were more than expected, and living in Tamworth was less fulfilling than expected. Perhaps with more formal support, these factors could have been overcome.

20. Tamworth Hospital also has a high locum usage to address workforce shortages in the short term. Traditionally reducing locum use has focussed on attracting more local staff. However, a tipping point appears to have been passed where there is so much locum/FIFO/virtual work available that there are few incentives to take a permanent job. Addressing locum usage in the long term is about creating a better local workforce but in particular, understanding why people become locums. Work needs to be done to disincentivise locums at least at a state or federal level with caps on salaries, where locums can work, and to incentivise permanent jobs simultaneously. If working as a locum is disincentivised, I believe these clinicians would be more likely to accept permanent positions, even those outside metropolitan areas.

21. Tamworth Hospital's reliance on locums impacts our continuity of care and planning. As a Gastroenterologist, I have a theatre list at Tamworth Hospital every fourth Friday of the month. The last three of our five lists have been cancelled because many of our regular

theatres lists are dependent on locum Anaesthetists who could not be obtained for these lists. Sometimes all the anaesthetists on site are locums. Some days almost all the specialists on-call in the hospital are locums. Local doctors have had to learn to be more vigilant when interacting with locums, especially regarding their frequently narrower skill set than local doctors, as well as decisions governed by the reality that they will not be seeing the patient for follow up and frequent handovers which provide opportunity for poorer clinical care.

22. The General Manager, the local Recruitment Manager, the Director of Medical Services, a Neurologist, an Anaesthetist and I have established a working group to assist with the recruitment of doctors to our facility. We meet to discuss current recruitment and retention strategies and provide advice on strategies. For example, the doctors in the group sometimes get in touch with candidates informally to discuss what it is like living and working in Tamworth. Our assistance also includes providing names of people who could be targeted with job advertisements and having input into the wording and location of advertising. Although unproven, the working group believe that improved medical recruitment outcomes will be achieved if doctors are involved in the recruitment process.

## G. MEDICAL STAFF COUNCIL

23. I am the chair of the MSC at Tamworth Hospital and I have held this position for four years. The MSC is relatively informal. We meet outside the hospital and focus on issues that affect multiple areas of the hospital. We try to be a vehicle to incorporate new doctors into the town and get to know people. My role is to co-ordinate that and represent doctors if they would like to raise issues with the Executive or elsewhere.

24. The MSC regularly communicates with the Executive of Tamworth Hospital. Yvonne Patricks, the General Manager of Tamworth Hospital, attends our meetings and presents on the facility's current challenges and initiatives and then leaves. As a smaller hospital, it is relatively easy to raise issues directly to the Hospital executive. Some doctors choose to raise issues with the MSC to raise them to executives on their behalf, and some like to raise issues with the executive directly. The MSC enjoys a good relationship with the local administration.

25. As chair of the MSC at Tamworth, I attend the Executive MSC (**MSEC**) meetings attended by the Chair of each MSC across HNELHD. The MSEC has recently been resurrected thanks to work of MSC chairs at John Hunter Hospital. It did not exist for a number of years, with meetings re-commencing last year. The Chair of the MSEC will then attend the board meetings for HNELHD. The benefits of the MSEC are:

a. that it provides a forum to share the issues that affect district hospitals, mid-size referral hospitals and tertiary hospitals, which are often quite different, but when seen together can provide new insights;

b. It provides representation to the HNELHD Chief Executive from a high-level body; and

c. feedback is received from the chair of the MSEC who attends the Board meeting about strategic decisions and priorities that may affect us.

David Scott

Dr David Scott

4 September 2024

Jeannine Lewis

Witness: Jeannine Lewis

4 September 2024