Witness statement

Name: Dr Matthew Ingram

Occupation: Staff Specialist Emergency Physician at Wyong Hospital

1. This statement sets out the evidence that I am prepared to give to the Special Commission of Inquiry into Healthcare Funding as a witness.
2. This statement is true to the best of my knowledge and belief.

Role

3. I am a Staff Specialist Emergency Physician at Wyong Hospital; I have been in this role since 2020. Prior to this I worked as registrar and junior medical officer in the Central Coast Local Health District between 2013 and 2020.
4. I completed a Bachelor of Medicine in 2012 from at the University of New England/University of Newcastle. I am a Fellow of the Australasian College for Emergency Medicine and an Associate Fellow of the Royal Australasian College of Medical Administrators.
5. I have been an elected councillor for the Australian Salaried Officers' Federation (ASMOF) since 2024.
6. I currently hold, or have recently held the following additional representative positions:
    a. ACEM National Program Steering Committee – since 2024
    b. ACEM Accreditation Committee – since 2023
    c. ACEM Trainee Progression Review Panel – since 2020
    d. NSW Health Pathology Clinical Council – since 2024
    e. Chair, Wyong and Long Jetty Medical Staff Council – 2021-2024
    f. Credentials (Clinical Privileges) Sub-Committee – 2021 -2024
    g. CCLHD Clinical Council – 2021-2024
    h. NSW Medical Staff Executive Council –2021-2024
7. I currently hold the following teaching positions:
    a. Conjoint Lecturer, School of Medicine and Public Health, University of Newcastle – since 2021
    b. Emergency Management of Severe Trauma Instructor, Royal Australasian College of Surgeons – since 2017
    c. Difficult Airway Workshop Instructor, Central Coast Local Health District – since 2023

d. Central Coast and Hunter Fellowship Course Facilitator – since 2019

8. Overall, I have seventeen years of full time experience studying and working in healthcare in NSW.

Medical Staff Councils and Communication with LHD Boards

9. I recently stood down after the maximum three consecutive terms as the as the Chair of the Medical Staff Council ("**MSC**") at Wyong Hospital, where I regularly attended board meetings for the Central Coast Local Health District ("**LHD**"). In my view, the LHD board is an appropriate and important platform through which the voices of the senior medical staff of the MSC should be heard.
10. Every LHD is different. The Central Coast LHD has four hospitals with three MSCs. The chairs of two MSCs are invited to attend the LHD board meetings. This structure has developed over time by custom and may be unique to the Central Coast LHD.
11. I feel that there is huge value in having both MSC chairs at our LHD board meetings. The Central Coast LHD has a reputation for being small but sees approximately 160,000 emergency patient presentations a year. The LHD serves a lower socio-economic populaiton with high rates of cancer. There is less access to primary care services in the LHD, and we see surges in our population during the holiday periods. The MSCs facilitate the visibility of medical issues to the board.
12. While the LHD board includes people from different professional backgrounds, for example lawyers, accountants etc; it is important that the frontline medical workforce is represented at this high level. I believe it adds a great deal of value, particularly to advocate for good clinical outcomes for patients.
13. There are also other avenues to address concerns raised by the senior medical staff in our LHD including the Medical Staff Council meetings themselves. We also have a Medical Staff Executive Council made up of the Chief Executive, the District Director of Medical Services and three MSC chairs who meet to discuss and attempt to address medical matters. However, where significant high-level risks arise, it is important for the LHD board to be aware of these issues and advised on addressing them.

Training, Accreditation and Workforce Distribution

14. I am on the accreditation committee for the Australian College of Emergency Medicine ("**ACEM**") where I review and consider applications for accreditation. Clinicians like myself, who sit on accreditation committees, feel a strong sense of responsibility in maintaining the standards of sites for accreditation. The accreditation of sites needs to be run by clinicians

first, as we understand the requirements of the training from having been through it ourselves and being responsible (in part, at least) for delivering the training program. ACEM cares about the impact that the quality of our training can have on patient care, as it is a huge part of what we deliver in our everyday jobs. ACEM also cares very deeply about trainee wellbeing.

15. A key task for clinicians and the colleges is deciding whether a training site is suitable for accreditation. Some colleges have rigid and well documented processes in their regulations to guide these decisions. Removing accreditation is not a solution, where for example cultural issues are present at a site, as it may result in reduced workforce. At the same time, leaving those issues unaddressed is unacceptable for trainees and patients. ACEM gives sites multiple opportunities to rectify those issues to maintain accreditation, the withdrawal of which is always a last resort after a lengthy, formal, and well documented process. The college's commitment is to patients, trainees, and the quality of the training provided.
16. Another issue is the extent to which a centralised or statewide approach could be taken to facilitate a more equitable distribution of trainees across NSW, and potentially Australasia. At present in emergency medicine, the number and availability of placements is determined by hospitals and LHDs. Metropolitan hospitals usually have higher demand to fill these positions as people may want to remain closer to family or other support systems. While other regional hospitals may struggle to fill any of their training positions.
17. I am an advocate for rural and regional healthcare, and I think the maldistribution of the workforce in those areas is a huge issue that needs to be addressed. One component to addressing this may be allocation of training placements. Some specialty trainees have accepted that they can be placed at any location across the Australia or in New Zealand for training.
18. I believe there is a greater role for collaboration to develop a more coordinated system for training placements. HETI has an established preferencing system for the internships they offer newly graduated doctors, which could be adapted to assist with the allocation of training placements. It could be developed with a view to try and give trainees their top preferences, accepting that this may not always be possible for some specialties where workforce shortages exist. These specialties may benefit from a more structured approach, whilst meeting the needs of communities across the state. It may result in a trainee getting their second or third preference, rather than their first. HETI allocated me for my internship in the Central Coast and I have been here since. I believe that rural and regional locations, including Wyong Hospital would benefit from this type of system.

19. To make rural and regional placements more attractive for trainees, I think there needs to be a much greater emphasis on the value gained from working in these locations. The exposure and generalist skillset that trainees will develop by working in rural and regional areas will prepare them for them for whatever path they want to go down in their careers and is of benefit to those already in a training program also.

Signature: 

Name: Dr Matthew Ingram

Date: 27/9/24