Special Commission of Inquiry into Healthcare Funding

Outline of Evidence of Dr Colin McClintock

Name: Dr Colin McClintock

Occupation: Renal physician, General medicine physician, and Board Member, Western New South Wales Local Health District

1. This is an outline of evidence that it is anticipated that the witness will give to the Special Commission of Inquiry into Healthcare Funding.

My role

2. I am a Board Member for Western New South Wales Local Health District (**WNSWLHD**). I have held that role since January 2017. I am also the Chair of the Health Care Quality Committee (**HCQC**) and have held that role since late 2023.

3. I hold qualifications in Bachelor of Science (Hon) Immunology (Edinburgh), Bachelor of Medicine (MBChB - Edinburgh), Fellow of the Royal Australasian College of Physicians (FRACP) Nephrology and General Medicine, Associate Fellow Royal Australasian College of Medical Administrators (AFRACMA), Masters Health Management (UNSW), and a Masters of Public Health (UNSW), and Diploma of Perioperative Medicine (Monash).

4. I am a full-time renal physician and general physician. I have been practising in Dubbo since 2007.

5. I am the Clinical Director of Medicine and Director of Physician Education at Dubbo Hospital, which is within the Royal Prince Alfred Hospital training network. In this role, I am actively involved in the annual recruitment and interview process for medical registrars.

6. I am also a regional clinical examiner for the College of Physicians, and a senior clinical lecturer at the University of Sydney.

Role of the Board

7. The WNSWLHD Board is broadly responsible for ensuring effective governance (clinical and financial) rather than operational management. In my view, it is very difficult for the Board to act as purely a governance body when it comes to healthcare. The Board is often drawn into operational matters, such as acute staffing problems that lead to failure of service delivery, particularly if this has been picked up by media. For example, in circumstances where there is ‘collapse’ of the local primary care system within a rural/remote town, the LHD may operate a multi-purpose facility (**MPS**) in that town and becomes the single remaining visible provider of healthcare, and the LHD can become operationally drawn into high-cost primary care provision without being funded to step into this role.

8. The Board holds 11 meetings annually on the first Wednesday of each calendar month except January.

9. The Board generally visits WNSWLHD facilities and meets staff on a monthly basis, and over a 3-4 year timeframe will aim to visit every facility. On occasion, this may involve visiting multiple facilities across 2 days and holding a Board meeting on one day.

10. Prior to COVID-19, the Board would meet regularly with community members and local hospital councils. WNSWLHD is currently restructuring its community engagement model, referred to as *Meaningful Engagement*. This involves a geographical sector approach, and I am on the Northern Sector community engagement team. This sector relates to Bourke, Brewarrina, Collarenebri, Goodooga, Lightning Ridge and Walgett.

Health Care Quality Board Sub-Committee

11. The Health Care Quality Committee (**HCQC**) is a Board sub-committee that meets every month the week before the Board meeting for 2 hours duration. A copy of the sub-committee's current endorsed Terms of Reference are at **Exhibit A**.

12. The HCQC is a District-wide governance tool that reviews clinical performance indicators, hospital-acquired complications (**HAC**) and incident data. Whilst monthly reports are circulated to HCQC members prior to the meeting for review, many of the reports will be verbally presented on the day by the Executive Director of Quality and Clinical Safety. HCQC receives monthly incident reports for the District, and reviews in detail severity assessment score (**SAC**) 1 and 2 clinical incidents, coronial matters, and clinical incident review outcomes. HCQC provides governance to clinical Morbidity & Mortality processes across the District and reviews data from multiple facility or District level clinical services (for example, the Blood Transfusion Committee). The meeting also involves a number of invitees across each year, to provide reports in different clinical areas – for example, an invited verbal presentation from the District Mental Health/Drug & Alcohol service regarding their Quality and Safety processes. The data is focused on clinical performance indicators, rather than individualised health outcomes more broadly, although we try to keep a clinical focus by including a 'Patient Story' in every meeting.

13. The HCQC looks at positive outcomes and areas of improvement. The HCQC role is to provide a framework for identifying trends of deteriorating outcomes, increased harm, or where it identifies the District is performing outside expected requirements, then ensuring the executive has a plan in place to address the issue, and then receiving updates via a feedback loop as to progress.

14. As a clinician, I also have the advantage of being able to robustly assess the data from a clinical perspective, and also see the context from clinical meetings in the hospital.

15. As an example, it was established in February 2024 that in-hospital thromboembolic event rates were deteriorating (as a monitored HAC) District-wide over a 3-4 month period, and we considered that there was a need to look at why this was happening to provide opportunities for positive intervention. At a subsequent hospital clinical council meeting at Dubbo Health Service (that I attend), it was discussed by facility management that a local team was being developed to directly address this issue. In turn, any subsequent improvement in the HAC for in-hospital thromboembolic event rates would be reviewed via the HCQC with this data also being monitored at District Board level (thus closing the feedback loop).

16. The HCQC can escalate items to the Board meeting, which follows in the week after, notified either by the Executive Director of Quality, Clinical Safety and Nursing (a Board attendee) and also via myself as HCQC Chair.

17. I have not experienced any significant challenges with integration of data in respect of my role but recognise that the current system of primary care delivery creates a problem for effective data monitoring more broadly across the District and the state.

18. In my role as a renal physician, I have observed a very robust system of reporting across Australia and New Zealand through the Australian and New Zealand Dialysis and Transplant Registry which feeds in and produces national outcome data. This is an independent process that provides annual mortality figures for renal transplant and dialysis patients and has no interplay with state healthcare data.

Renal Medicine Service Model and Outpatient Clinics

19. WNSWLHD has 3.8 FTE renal physicians in Dubbo. This makes Dubbo Health Service the only fully staffed medical specialist entity in the Dubbo Hospital clinical service area. This enables WNSWLHD to provide a general nephrology service to both Dubbo's primary and secondary catchment populations (via an outreach model of care).

20. The renal service is based in Dubbo but has a 'hub and spoke' model of specialist outreach clinics delivering bulk-billed services to Bourke, Brewarrina, Cobar, Coonabarabran, Mudgee, Walgett, and Warren. WNSWLHD has also developed a network of dialysis running in remote facilities which meets the state requirements that patients should not have to travel more than 115 kilometres one way to receive haemodialysis. Nobody has to travel more than 100 kilometres in the Northern sector of WNSWLHD to access a renal physician. Provision of a clinical model in nephrology like this provides an excellent support to primary care practitioners, ensuring they have a robust, timely referral route for their renal patients.

21. We have thereby successfully developed a comprehensive and longstanding service delivery model for renal medicine in WNSWLHD with Dubbo resident senior clinicians. Dialysis provision is incredibly important in our District because people are approximately 200 times more likely to require dialysis living in Brewarrina than in central Sydney. Whilst the service delivery model for renal medicine is designed to support people living in the rural and remote areas, it also has an important role in providing care on country for Indigenous Australians.

Opportunities

22. In my view, a solution for providing specialist care across the west of NSW is to follow a similar approach to that developed in renal medicine in WNSWLHD for other sub-specialties. This process can be repeated for other high patient volume clinical subspecialties, such as cardiology and gastroenterology. This has been done for medical oncology in WNSWLHD which is now fully staffed via establishment of the Western Cancer Centre. There are some services or specialties that will always be referred out to metropolitan areas, such as cardiothoracic surgery.

23. This process should be driven by first deciding what key services a geographical population can expect and should receive across all subspecialties, developing a model of care for delivery of that subspecialist care, developing a workforce plan to deliver that care, obtaining funding commitments, and then developing the workforce subsequently.

24. Otherwise, service delivery is often self-driven and relies on individual specialists championing for the service.

25. It must be understood that the impact of a missing key clinical subspecialty (that is, dermatology) in regional/remote NSW will have a far greater impact than in metropolitan NSW, where a patient can simply travel further across town to access their care. A missing service in regional/remote can lead to a 700km road trip to access care, or can mean that the care is not received at all.

26. In my view, the overarching strategy (including workforce) and funding for such specialist care should be directed by the Ministry of Health, and the process should be implemented at a LHD level.

27. Workforce requirements would likely present the biggest challenge. It may require an integrated vertical recruitment process where the state government recruits Staff Specialists directly in order to meet the numbers of specialists required, as compared to the VMO model which is overlaid with the funding split between the state and the Commonwealth. Driving a staff specialist recruitment model ensures equitable access to specialist services for regional/remote patients given the clinics will be bulk billed.

28. Much has been said regarding how to attract a medical specialist (and also general practitioner) workforce into regional/remote areas of Australia. Where possible, the workforce should be permanent resident (as opposed to fly-in-fly-out), as this provides the best possible stakeholder engagement for those practitioners into service standard/implementation and improvement. A basic reality that we face, is that financial incentive is required and current incentives at a state and national level require urgent review, particularly given the financial challenges to the system of prevalent 'high cost-low value' locum medical workforce. A simplified approach to financial incentives could be agreement at Commonwealth level to a geographically graded (by distance from state capital to primary site of medical practice) income tax offset for example.

29. An additional benefit of developing a comprehensive specialist service to regional/remote areas of NSW is the broad support this provides for primary care, and I believe would provide a significant uplift in general practitioner retention.