Special Commission of Inquiry into Healthcare Funding

Statement of Dr Ralph Cheng

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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 and 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 experience at Grafton Base Hospital, 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 the Head of the Medicine Department at Grafton Base Hospital, Northern New South Wales Local Health District (**NNSWLHD**) and have held this role since 21 February 2023.

4. I hold a Bachelor of Medicine from the University of Hong Kong and completed my training as a physician in Hong Kong, where I was an associate consultant at Tuen Mun and Pok Oi Hospitals. I commenced work in Australia on 11 February 2019, as a staff specialist General Medicine Physician at Grafton Base Hospital, a role I continue to hold concurrently with the Head of Medicine role.

5. In my role, I receive referrals from the Emergency Department and other departments, treat patients on an acute medical ward and in clinics and supervise Junior Medical Officers (**JMOs**). Those JMOs are not in training programs, as Grafton Base Hospital is not a training centre for doctors working in medical wards, whether RMOs or Basic Physician Trainees (**BPT**s). I do have training skills and am accredited to train BPTs and to supervise, higher physician training (**HPT**) in Hong Kong, including in the subspecialty of nephrology. I also undertake on-call and administrative duties.

6. A copy of my curriculum vitae is exhibited to this statement (MOH.0010.0637.0001).

B. CURRENT OPERATIONS

Grafton Base Hospital

7. The General Medical Team at Grafton Base Hospital is comprised of four General Physicians who manage their respective sub-teams. The physicians need to be able to practice as general physicians. Some of them hold dual fellowships such as general physician plus cardiology or neurology, but they must be able to manage a general physician patient load as their primary focus. I also hold a dual fellowship, one in General Medicine (both in Hong Kong and Australia), one in Nephrology (Hong Kong only). Of those four General Physicians, I am the only full-time staff specialist. One of the other Physicians is a permanent part-time staff specialist who works one in every four weeks. The remaining positions are filled by Locum Medical Officers (**locums**), discussed further below. The Hospital seeks to ensure that there are always four General Physicians working in the hospital at any one time on weekdays during business hours. There is only one physician on call from 4.30pm until 8.00am the following day each day.

8. Each General Physician is responsible for managing a sub-team and patient load each day. The patient load is divided more or less evenly between each of the sub-teams at the commencement of each working week (usually Monday or the first day back after a long weekend). For patients who are re-admitted to the hospital within a specific period, they are re-admitted under the same care sub-team. However, due to the staffing structure and reliance on locum physicians, the patient may not remain under the care of the same General Physician by whom they were previously cared for.

9. On weekdays, the roster of employees in the general medical team is as follows:

    a. Four daytime Resident Medical Officers (**RMOs**) and four physicians (made up of staff specialists and locum physicians) who work from 7.30am to 4.30pm;

    b. One evening RMO who works 4.00pm to 12.00am; and one on-call physician who is off-site and is contacted for admissions and advice.

    c. One night RMO who works 12.00am to 8.00am and the same on-call physician who is off-site and is contacted for admissions and advice.

10. On weekends (and sometimes public holidays), the roster of employees in the general medical team is as follows:

    a. Two daytime RMOs who work 7.30am to 4.30pm and one on-call physician who would come to do ward rounds in the mornings with the RMOs to assess

newly admitted patients and unstable/sick patients and is otherwise contacted for admissions and advice.

b. One evening RMO who works 4.00pm to 12.00am;

c. One night RMO who works 12.00am to 8.00am; and

d. One on-call General Physician who comes to do ward rounds in the morning and remains on call from 8.00am on Friday until 8.00am on Monday and is contacted for admissions and advice. I am the on-call physician every second Friday and come to see my patients on Saturday then either I or another on-call physician is on call from 8.00am Saturday until 8.00 am Monday to be contacted for admissions and advice.

11. I share a number of 'on-call' duties each month with the other three Physicians (including the locum physicians). The on-call duties are not always equally divided depending on the availability of locum physicians.

12. As a staff specialist, I am also required to attend clinics and regular meetings, including clinical incident reviews, medical quality meetings and other administrative meetings, I am also responsible for handling complaints and setting up orientation and education programs. Locum physicians are not required to participate in clinics or meetings as, in general, they are not allocated governance or follow-up activities due to their lack of permanent attachment to the site.

13. Whilst there has recently been an increase in the number of RMOs to a total of four during the day, they are not able and not expected to manage patients independently. The Physician must provide oversight of their RMO and will bear responsibility for any poor outcome or clinical incident. RMOs can take responsibility for attending to minor issues like taking blood samples when phlebotomists are not available or unable to. RMOs also see deteriorating patients in the ward and may provide initial treatment based on the previously agreed plan. In that case, they are expected to report to physicians to devise an ongoing plan, which may be to review the patient together. New referrals and admissions are seen by both the physicians and their respective RMO.

14. The hospital's General Physicians are the first point of contact for the Emergency Department and other teams for referrals at any time during the day and overnight, including when the General Physicians are on call. General Physicians are the first point of contact for medical referrals from the Emergency Department and other departments.

Inpatient matters are initially managed by team RMOs during office hours, and the evening and night RMO after office hours, and escalated to the General Physician on-call if of a serious nature.

15. In addition to on-call duties, General Physicians are required to take on a heavy patient load in the course of their regular duties. There is no maximum cap on how many patients are managed by each medical team. The hospital has closed beds and wards, which are not in the standard hospital bed count. In addition, the hospital is able to allocate surgical and other non-medical beds to medical patients as necessary as demand increases. At peak times, the Department of Medicine at Grafton Hospital can have up to seventy patients, which can create excessive workloads given our current staffing levels.

Regional support

16. There is a lack of subspeciality support in the Grafton region, both at the Grafton Base Hospital and locally. This means that all patients are cared for on-site by the General Physicians (including sometimes General Physicians who happen to also have a relevant subspecialty qualification), which adds to the patient load of the General Medical Team. That is because in other hospitals with similar patient numbers and same physician team numbers, they may have additional subspecialty physicians on-site, for example respiratory physicians and cardiologists, which reduces the need for the General Physicians to coordinate care with the sub-specialty physicians. In those hospitals a patient admitted with or developing a respiratory problem would have their care shared with or taken over by the other specialties. For example, a medical patient diagnosed with lung cancer would be transferred to the respiratory physician team, at a hospital which has respiratory physicians. This information was shared to me from a locum physician Dr Manoharan who works in Ballarat.

17. Grafton Base Hospital also provides support to Maclean District Hospital, a local community, Level 3 rural hospital in NNSWLHD. Support is provided to Maclean District Hospital for ED patients and inpatients whose care requires escalation. However, in practice, such support is also provided when there is an overflow of patients because Maclean District Hospital is at full capacity. This means that patients who may not be clinically indicated for transfer to Grafton Base Hospital will be transferred due to capacity issues, increasing the workload on the Grafton Base Hospital staff. If every bed is full at Grafton including specially opened beds, referred patients may have a prolonged stay in ED until a bed becomes available due to discharge.

18. The ageing population of the Grafton community and the very limited nursing home beds and service packages leads to significant numbers of elderly patients remining in Grafton Base Hospital waiting for availability of a residential aged care bed or services to allow them to return home. This has an impact on the workload of the General Medical Team, as these are patients being managed in the hospital environment when they could be managed in the community, if community resources were available. Although each of these patients may be less acutely unwell than other medical patients, their issues such as frailty and behavioural symptoms still require management These patients still need to be seen regularly by the General Medical Team. There have been incidences when long staying patients have contracted hospital acquired pneumonia or even COVID-19 infections, requiring renewed and ongoing medical care.

Locum reliance

19. The employment of and management of locums is governed by the NSW Health Policy Directive PD2019_006 *Employment and Management of Locum Medical Officers by NSW Public Health Organisations* (MOH.0011.0005.0001), which provides that they are only to be engaged as a last resort in service-critical areas, when all options to ensure service delivery have been exhausted.

20. Locums at Grafton Base Hospital are sourced from a casual medical pool or from locum agencies. Some vacancies are long term, as no permanent of long-term contracted staff can be found to fill them. Recurring locum use is common. In addition to the locums engaged to fill at least two of the General Physician roles at Grafton Base Hospital at any one time, all of the RMOs are also locums. That is because there is no training program for medical RMOs at Grafton, so there is no supply of RMOs except through the locum market. There is a catch-22 issue in that without sufficient permanent specialists, one cannot get a training program accredited. And without RMOs in training, it is difficult to attract permanent specialists. Junior doctors generally work either in the training environment, building their career progression, or in the locum market. Non-training salaried roles are not competitive in the junior doctor market.

21. There are several limitations that arise from reliance on locums who are not permanent staff of the hospital:

    a. Locum physicians do not have any long-term commitment to Grafton Base Hospital which can present as a challenge to continuity of patient care.

b. As locums are not required to undertake ongoing training with respect to the hospital's policies and procedures, where there is a high variance in staff there is an increased administrative burden in keeping new locums updated in relation to such policies and procedures. For example, there is a current IV fluid shortage at Grafton Base Hospital and all new staff have to be regularly reminded of this to assist in management of IV fluids.

c. There is a high variance in the quality and experience of locum RMOs, including RMOs who are unfamiliar with the hospital and computer systems, and this can increase training and support requirements in an already busy hospital environment.

22. Recruitment of more than four General Physicians is not feasible, as we are unable even to attract four permanent staff in these roles. Four permanent General Physicians would be able to provide adequate current services other than at peak times. At peak times, four teams would each have between 15-22 patients, with the team on call having a higher workload than the others. That would still not be sufficient to meet the demands of the range of outpatient clinics which we would like to provide. These clinics could be used to help keep patients out of hospital, or assist in earlier discharge with, with effective out-patient clinical follow-up/management. Five physician teams would meet the surge capacity. If locums, they would still not be expected to provide all of the desired clinics, as locums do not provide clinics or governance services. As permanent staff, five physician teams could supply a relatively full range of inpatient and outpatient activities.

C. RETENTION AND RECRUITMENT CHALLENGES

Workload and training

23. Over the course of the past four years, Grafton Base Hospital has had a turnover of approximately twenty Staff Specialists, including four Physicians. There has been difficulty in retaining staff specialist physicians. My specialist colleagues have advised me that this is the total if we count all staff specialists (including ED, paediatrics, obstetrics/gynaecology, physicians) that have left since I started working in Grafton. Locum physicians I have spoken to indicate that discouraging factors to attraction and retention include poor work-life balance and a high patient load, caused by a lack of permanent staff and insufficient JMO support.

24. The solution to this problem is difficult because the lack of permanent full-time staff specialists to provide supervision means that there is no ability to start training programs for Basic Physician Trainees, who could provide support to the Physicians.

25. Grafton Base Hospital receives very few applications from Australian trained physicians. Given this and the Hospital's reliance on international medical graduates (**IMGs**), it appears to me that Australian specialists prefer not to work in regional hospitals such as Grafton Base Hospital and instead seek positions in metropolitan areas, where the working conditions and training opportunities are considered to be better.

26. I am involved in Staff specialist physician recruitment and participated in the interview panels in the last few years. All the candidates we have interviewed were IMGs. When I asked a few locum RMOs if they would like to work in a Core Generalist training position within ACRRM (Rural Medicine) at Grafton, given that we have successfully applied to be a training centre for Core Generalist, I was told they would prefer to work in metropolitan areas. I was also told by other locum physicians that they have interns and registrar coverage in metropolitan hospitals. For an already qualified physician, working in major hospitals/tertiary hospitals would lead to better exposure to new medical/clinical advancement in subspecialty teams. I previously worked in a hospital with nearly 2000 beds in Hong Kong and continuously learned new advancement from other subspecialties as we took turns to present in hospital grand rounds and journal clubs. In regional hospitals, there are fewer such opportunities as there are no subspecialty teams.

27. For physicians willing to work in a regional area, the greater registrar support, and thus decreased workload, available at the nearby Coffs Harbour Health Campus (approximately 1 hour from Grafton) makes it a more attractive place to work than Grafton Base Hospital. This information comes from a physician who used to work at Grafton but left to work at Coffs Harbour due to its better working conditions.

28. Although the Hospital has received multiple applications from IMGs (both for physician and JMO roles), the vast majority of such applicants are unable to meet the employment requirements set out by the Australian Health Practitioner Regulation Agency.

29. Additionally, the Royal Australasian College of Physicians often requires that two named staff specialists are available to supervise IMG specialists while they demonstrate their competence in the Australian system. Supervisors need to have a relatively constant and long term presence at the training site, which does not match our locum VMO locum

turnover. This is very difficult to achieve where there is only one full-time staff specialist and there is a large gap in recruitment that needs to be addressed. So the gap in permanent specialists cannot be filled with new to Australia IMG permanent specialists, as they are not approved for supervision by the College at a site without sufficient permanent specialists to oversee them.

Remuneration

30. The current salaries and packages available to permanent staff specialists also present a challenge to ongoing retention. To my knowledge, locum staff receive better renumeration, including for weekend work and on-call duties, despite having reduced duties in comparison to staff specialist General Physicians. Staff specialist General Physicians are only renumerated through the Staff Specialist Award with an on-call allowance that does not adequately reflect the amount of time and work required in undertaking on-call duties in the Grafton site. This is a deterrent for potential employees of the Hospital and encourages medical practitioners to seek engagement as locum practitioners.

31. Physicians are also not protected by a maximum number of working hours or fatigue provisions. Whereas there are some protective measures for JMOs, who have a maximum number of working hours, and RMOs, who work only their rostered shifts. Physicians can be called at any time to provide care. This, together with the lack of renumeration for overtime/weekend work for staff specialist employees, is a disincentive for retaining staff.

32. Additionally, there are no private hospitals in the area to supplement income through undertaking private work, which again limits the renumeration available to physicians.

Proximity to the Queensland Border

33. The primary challenge that arises from our proximity to the Queensland Border is the significant salary differences between staff specialists at interstate hospitals. The renumeration offered at Queensland hospitals is significantly higher and is also provided with additional benefits, such as a general training fund, $20,000 for car subsidies and increased pay bonuses for working in remote areas. I became aware of this through speaking to one of our locum physicians from the Gold Coast, Dr Daniel Chiwanga and I have also spoken to a job agency 2 months ago regarding work in Queensland. In contrast, the ‘TESL’ training fund available with NSW Health requires specific application for items, with funds not always exhausted and then lost, no car subsidies are available

and there are no bonus incentives available for working remotely. I requested access to the Rural Health Workforce Incentive Scheme through NNSWLHD when they were first offered but it was never paid. I re-raised the issue in recent months, and they said the incentive bonus eligibility was cancelled after I took up the head of department post.

Social factors

34. Recruitment of permanent staff to Grafton Base Hospital has been difficult, not only due to direct workforce challenges outlined above, but also due to broader factors, such as the socio-economic environment and accommodation options. This information was provided by nursing colleagues who had difficulty renting a house when moving to Grafton and my general impression after looking after local patients for 5 years, noting that some of them have been living in a caravan for years. They have now grown older and are unable to get into the caravan themselves.

35. I have discussed this issue with our locum physician Dr Steven Flecknoe-Brown. He has written a report on this issue as, with most rural centres, the social determinants of health deteriorate the further one goes from a capital city. The Australian Cancer Council's Cancer Maps and the National Heart Foundation's Heart Maps show the gradient in heart disease and cancer incidence between the capital cities and outer regional areas. The difference in life expectancy is measurable in decades. Housing stock in the town centre of Grafton is old and mainly of weatherboard construction, with newer estates developing around the town fringes. Average household incomes and education levels are low by Australian standards. Poor health literacy, high rates of obesity, decreasing amounts of regular exercise and persistent cigarette smoking are significant lifestyle factors in ill-health. People living in cities like Grafton have often had their family living there for three or four generations. The values of their homes have not grown nearly as much as those in bigger regional centres or the metropolitan area. Even if they wanted to leave, they cannot afford to. The result of this is that health services in the Clarence Valley, as in so many other regional NSW centres, are dealing with an ageing, ailing population.

36. My impression on the accommodation problems comes from observation and information from local social media. I have observed that there are very limited rental properties for people to relocate to Clarence Valley due to lack of newly developed properties and influx of people to this area since the opening of the highway connecting to Gold Coast. Residents from Lismore have also moved to this area after the flood a few years ago and they have not moved back to Lismore (this information is from my previous patients who used to live in Lismore).

Potential Solutions

37. A potential solution to the current staffing issues would be for Grafton Base Hospital to become an accredited training hospital with the Australian College of Rural and Remote Medicine (**ACRRM**). Grafton Hospital is currently accredited as a centre for general core training under ACRRM, however, we are trying to obtain accreditation to offer higher, registrar level training. Our Director of Medical Services (**DMS**) and myself are working on this application to become a training centre with involvement of a GP Dr Dean Robinson from Maclean Hospital. I am also hoping they would accept the supervision and training provided by our parttime staff physician Dr Hakmi.

38. If Grafton Base Hospital were to become an accredited training centre, this would encourage more junior level staff and trainees to work at the hospital, providing more support to senior staff. However, it must be acknowledged that ACRRM trainees would require a high level of support and sufficient relief from clinical duties to make time for tutorials, study, and other curriculum requirements. Under the current structure this may not be feasible due to the high workload that ACRRM trainees would be expected to carry as they would replace the locum RMOs in our current teams. The ACRRM trainees would hopefully stay for multiple training terms and support a stable workforce. Any ACRRM trainees are less productive initially, but they could assist in providing registrar level support after a sufficient period training. The longer term and more sustainable goal would be to have a physician training program and BPTs.

39. Rural generalists or GPs could potentially fill in the vacancies of the locum RMO and physicians in our hospital. They are qualified GPs so have more skills than junior hospital doctors, but less hospital medicine skills than qualified physicians. Many years ago, when there were not many general physicians, the medical department was run by one physician and a few local GPs. The physician looked after complex patients and gave advice and support to the GPs. The patients could be looked after by the GPs in the community after they were discharged. This model of care could potentially be used again in our hospital when there is continuous shortage of permanent physicians. However, the capability of trained GPs (including rural generalists) is not the same as physicians, so there is a problem with quality of care and adequate supervision by physicians if GPs (who are also in very short supply) were used. Getting more physicians in the future depends on having physician training programs and BPTs.

40. Lismore Base Hospital (**LBH**) could help our workload challenges in a few ways. For workforce issues, if Grafton Base Hospital could be involved as a training centre, trainees

from LBH could be seconded to work in GBH regularly as part of their training at LBH and support workforce shortages. Basic physician trainees and higher physician trainees should be required by the College of Physicians to spend more time in regional hospitals as part of their training program. If this can be enforced state wide, a lot of workforce issues in regional areas could improve. This is also important for trainees as they should be exposed to different settings and see how things work in hospitals with less subspecialty support. In terms of patient load issues, if the waiting time to get a bed for patients who have been accepted to LBH could be shortened, it would mean less time spent in our hospital waiting for procedures. This has happened multiple times when patients who required coronary angiogram at LBH needed to wait 1-2 weeks to get a bed at LBH. This could potentially lead to delayed management and adverse outcomes in our patients. LBH as the only referral centre for cardiac problems in our LHD can be very busy and unable to accept our patients. Tweed Valley Hospital needs to develop its cardiac catheterisation service as soon as possible in case LBH is full or access to LBH is not available due to natural disaster like floods and bush fires (both of which have caused issues before).

41. Another measure which would relieve the workload of staff specialist General Physicians would be to implement protected administration days. This would allow staff specialists to attend to administration duties, including safety, quality and governance activities, outside of their role in acute clinical care. This would require there to be sufficient cover by other physicians.

Dr Ralph Cheng

11/9/2024

Date

Witness: Wai Yu Ada Ng

11/9/2024

Date