Special Commission of Inquiry into Healthcare Funding

Statement of Dr Paul Craven

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1. I have provided a statement to this Inquiry dated 7 June 2024 (**MOH.9999.1289.0001**). This, my second statement, accurately sets out the evidence that I would be prepared, if necessary, to give to the Special Commission of Inquiry into Healthcare Funding as a witness. The statement is true to the best of my knowledge and belief.

2. The statement 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 the Executive Director of Children, Young People and Families (**CYPF**), Medical Services, and of Networks and Streams, at Hunter New England Local Health District (**HNELHD**). I have held these positions since February 2019, and June 2023 for the latter two positions. A copy of my CV is exhibited to this statement (**MOH.0002.0005.0001**).

4. As set out in my statement dated 7 June 2024, as the Executive Director of CYPF, I am responsible for managing and leading the Hunter New England CYPF services, including those of the John Hunter Children's Hospital (**JHCH**) and in the community, and I co-lead the CYPF Health Network in NSW, with the Executive Director of Sydney Children's Hospitals Network (**SCHN**) and the Chief Paediatrician.

5. My statement dated 7 June 2024 addressed the operation of JHCH through the CYPF Network, JHCH's relationship to the SCHN, differences in funding of JHCH to that of other dedicated children's services, inequities and challenges of delivering speciality children's services for rural and regional communities, and difficulties of implementing the recommendations of the *'Review of health services for children, young people and families within the NSW Health system'* (**Henry Review**).

6. As set out at paragraph 13 of my previous statement, both JHCH and SCHN are members of the CYPF Executive Steering Committee. I further note I am also co-chair

to this Steering Committee along with the Deputy Secretary of Health System Strategy and Patient Experience. This Committee is developing governance structures on the provision of paediatric services in New South Wales. We are currently mapping the paediatric service capability across the state which is expected to be completed in February 2025. The service capability mapping will enable NSW Health to identify gaps in our service provision across the state, identify what we are doing well, and plan future services.

7. My role as Executive Director of Medical Services includes oversight of workforce planning and initiatives, governance, well-being of junior and senior doctors, education, and accreditation for senior medical staff. This relates to both paediatric and adult roles.

8. In my role as Executive Director of Networks and Streams, I am responsible for the strategic planning of the nine networks that operate across HNELHD. These Networks include CYPF services, Women's Health and Maternity, Aged Care and Rehabilitation, Procedural Network, Critical Care, Palliative and End of Life Care (**PEOLC**) and the Cancer Network. Each Network has an Executive Sponsor. Currently I am also the Executive Sponsor for Cancer, Procedural, Critical Care, PEOLC and CYPF services. As HNELHD has recently had an organisational restructure, the Networks are planned to be embedded in this new structure by November 2024. My role as Executive Director of Networks and Streams and Executive Sponsor of the abovementioned networks will be transferred to relevant HNELHD Executives. The Networks and Streams Executive role also relates to both paediatric and adult services.

B. MEDICAL OFFICERS

9. HNELHD faces difficulty with recruiting and retaining medical staff, particularly at our regional and rural facilities. These difficulties are multifactorial and include a reduced pipeline of staff wishing to work in rural and regional settings, inequity in staffing ratios in some sites resulting in arduous rosters, and a lack of flexibility of remuneration options. For example, a lack of flexibility with staff being able to work part-time as a Staff Specialist and part-time Visiting Medical Officer (**VMO**) at the same facility or District, and lack of interest to the fee-for-service VMO model in regional and rural facilities with lower activity levels. We are also experiencing new Junior Medical Officers (**JMOs**) and Senior Medical Officers (**SMOs**) choosing to work in other states where remuneration and settlement packages are higher. The main reason people do choose HNELHD is for the lifestyle we offer across our region.

10. In response to HNELHD's difficulty with recruiting and retaining medical staff, in 2023, HNELHD established a Medical Directorate consisting of myself and Ms Kathy Ingham, Medical Programs Manager. The Medical Directorate has conducted extensive consultation with clinicians, students, managers and other leaders and administrators across over 30 of HNELHD's hospitals.

11. Following this consultation, the Medical Directorate developed a Medical Workforce Action Plan which identified several priority areas including:
    a. Medical Students;
    b. Junior Medical Officers;
    c. International Medical Graduates;
    d. Senior Medical Staff; and
    e. Accreditation.

12. The Medical Directorate meets monthly with the Director of Medical Services (**DMS**) of each facility, the JMO manager and the SMO manager to discuss the priority areas. HNELHD has now fully recruited to all DMS positions across the District, which has improved communication of the workforce challenges faced at each facility with the HNELHD executive.

(i) Medical Students

13. HNELHD operates a joint medical program with the University of New England (**UNE**) and The University of Newcastle (**UON**) and has a good relationship with these universities. Medical students are a crucial pipeline for the HNELHD workforce. Accordingly, their satisfaction with their experience at HNELHD facilities during their student placements is very important for HNELHD's future recruitment and retention of staff.

14. Following the establishment of the Medical Directorate, feedback was received from medical students that HNELHD was not the most engaged LHD with their universities, and that some students did not always feel valued when they did placements at our facilities. They also commented that HNELHD facilities and Information and Communications Technologies were poor.

15. Since my commencement in this role, I have been working with the universities to address the problems raised by the students. HNELHD now meets with medical students in their third to fifth years of their study (clinical years) to discuss areas for HNELHD to improve and increase student satisfaction. This is also an opportunity to welcome medical students to HNELHD and ensure they are aware they are valued by HNELHD, and that we are here to supervise, teach and make their experience the very best possible. Initiatives responding to this feedback include the development of a Joint Student Council this year, with attendees from HNELHD and the universities, enabling HNELHD to understand and address issues raised by students promptly.

16. In response to feedback about HNELHD's facilities including, the adequacy of its lounge areas, HNELHD is working to upgrade our facilities where students are placed, including John Hunter Hospital where half of our students are based. This includes a newly refurbished lounge and study area, as well as access to the newly developed Health Innovation Living Lab. We also recently held a careers night which was well-attended, with 15 specialist speakers, and 161 students attended. This addressed both career pathways and also lifestyle choices for living across HNELHD.

17. It is too early to tell the success of these changes; however I am hopeful they have improved the students' experience. Additionally, HNELHD is also in the early stages of looking at opportunities to develop an education and training precinct for medical, nursing and midwifery and allied health students.

18. Further, the Assistant in Medicine (**AIM**) program was a role designed for 5th year medical students, developed and implemented as part of NSW Health's COVID-19 response. The position was successful, particularly at Manning Hospital. There is an opportunity for HNELHD to roll out AIM positions at strategic sites, subject to available funding. The anticipated medium to long-term benefit is to have more locally trained doctors staying on to work as JMOs.

(ii) JMOs and Senior Resident Medical Officers (SRMOs)

19. The national deficit of doctors, including JMOs, Post-Graduate Year (**PGY**) 1 and PGY2 doctors is exacerbated in HNELHD. There are also deficits in specialised training Networks such as Medicine, Paediatrics, Surgery. One of the primary reasons for the JMO deficit is remuneration. JMOs are leaving HNELHD to work in other states for more competitive remuneration or are otherwise leaving HNELHD to locum in other LHDs, generally once they reach PGY3.

20. HNELHD is part of the NSW Prevocational Training Network 12, which has historically been popular, but post COVID has lost some of its standing. Since commencing in this role, I have spent a lot of time talking with our JMOs to understand the problem. I attend the JMO Hunter Regional Medical Officers' Association monthly meeting with Ms Kathy Ingham, and we also meet monthly with a group of JMOs from HNELHD.

21. On 11 December 2023, the Medical Directorate also hosted a one-day JMO forum, attended by 90 people, including 20 JMOs and other clinicians representing HNELHD's various facilities. The goal of the forum was to further develop HNELHD's understanding of the JMOs' experience and identify strategies for improving their experience, recruitment, retention and wellbeing of JMOs in HNELHD.

22. HNELHD has also established a JMO working party, chaired by the Director of Prevocational Education at John Hunter Hospital, that meets monthly to enact the matters raised in the Action Plan, including improving rostering, education and training, and JMO facilities such as sleeping quarters and lounges. JMO Managers and Directors have worked to improve JMO rostering by increasing equity of shift selection. Another change we have made is by not approving JMOs taking leave without pay for the purpose of working as a locum at other HNELHD facilities.

23. I believe we have come a long way to improving JMO wellbeing and have received positive feedback during our regular meetings with the JMOs. This year our retention of PGY1 and PGY2 JMOs has improved, which I believe is attributable to the abovementioned changes.

24. By way of complete overview of prevocational medical officers at HNELHD, SRMOs in HNELHD are PGY3+ medical officers in both training and non-training positions. At HNELHD, the SRMO Network is one of 4 managed Networks, centrally coordinated by Managers and Directors. The other 3 managed Networks include Basic Physician Training, Emergency Department training and Prevocational Training Network. All specialist training Networks are managed by craft specific managers, such as in Anaesthetics, ICU or Paediatrics.

(iii) International Medical Graduates (IMGs)

25. HNELHD employed approximately 200 new IMGs in 2024. IMGs employed as junior doctors are generally classified as PGY2, however some are in SRMO roles, and some are in a specialist training programs. Some IMGs do come and follow a specialist training

pathway where supervision requirements by colleges are stipulated. IMGs come from a range of countries around the world, with varying levels of experience.

26. One of the primary challenges of recruiting IMGs is the difficulties managing visa applications and meeting Australian Health Practitioner Regulation Agency (**Ahpra**) supervisory requirements, which deters potential applicants, places strain on local supervisors and indeed many small hospitals cannot meet such requirements. Some IMGs JMOs were senior doctors in the country they relocated from and have to go back to being interns/residents. Many IMGs applying from non-competent authority countries need to obtain non-specialist general registration to practice in Australia, and train through the standard pathway. The countries recognised as competent authority pathways are the UK, Canada, the USA, Ireland, and New Zealand.

27. To gain general registration undertaking the standard pathway with Ahpra, IMGs must pass the Australian Medical Council (**AMC**) part 2 exams. There are 2 ways to be successful in AMC part 2 exams. IMGs can either do the exam itself which has a relatively low pass rate or can do the workplace-based assessment (**WBA**) program over a 6-month period, which has an excellent pass rate.

28. HNE offers 60 candidates per annum access to the WBA program. The program consists of 12 clinical exams, 6 case-based discussions, and one 360-degree feedback session. Whilst extremely successful, it does create extensive supervisory requirements for our senior staff, which have been stretched providing supervision for medical students, prevocational JMOs, unaccredited trainees, IMGs, and also specialist training requirements stipulated by colleges.

29. Standard pathway supervisory requirements are further stretched by Ahpra supervision requirements for IMGs which are often on level 1 or 2 supervision, requiring 60-100% of supervision to be face to face. While the need to maintain accreditation standards is understood, more flexibility with experienced IMGs would facilitate HNELHD to be able to recruit and retain IMGs to meet healthcare demand.

30. Some IMGs working at HNELHD coming from competent authority countries (for example, the UK) and are following a specialist pathway

31. have been rated substantially comparable in quality to Australian trainees and are required to undertake one year of supervision. Some sites in HNELHD are struggling to meet supervision requirements of these senior doctors, because they are not accredited with local colleges, despite having specialist who could adequately supervise.

32. Whilst supervision is appropriate, these senior doctors are required to be supervised at facilities accredited by colleges such as the Australasian College for Emergency Medicine (**ACEM**). Many of our regional and remote facilities, which have less senior medical staff, are often no longer accredited for training, despite having fellows of ACEM on site. Whilst I understand these facilities cannot train JMOs in such speciality areas, those coming from certain countries such as the UK, where they are found to be substantially comparable, could be remotely supervised and this would help greatly. This would allow IMGs from such countries to work in our hospitals with most need, receive remote supervision and proceed to gain their year's supervision requirements. If we cannot place IMGs at our sites with remote/virtual supervision, there are limited options for filling such roles, as we are not attracting local graduates, and we will see further decline in our workforce.

33. HNELHD is also working with the Ministry of Health (**MOH**) to identify some of our facilities as 'Areas of Need' (**AON**). By identifying and establishing some of our facilities as AON, the program will assist HNELHD to recruit IMGs to vacant positions, with supervision of the IMGs being conducted hopefully remotely. A potential challenge with this program is that the positions are temporary, and the IMGs in such positions want to train to obtain specialist college accreditation. If the IMG is unable to obtain specialist college accreditation during this period and move to a permanent position, their temporary position is at risk if the facility does not remain classified as an AON. Establishing a dedicated pathway whereby IMGs in AON positions train to obtain specialist college accreditation, with supervision the same as provided for the AON position, and general registration would enable IMGs to stay in their position at the AON facilities as local specialists. This would also improve recruitment and retention of IMGs, as IMGs are often leaving countries with their families and where they have held very senior positions that they may not be able to return to, and would be more attracted to longer term guaranteed positions.

34. Another challenge for HNELHD in having such a high number of IMGs is the challenges IMGs face when integrating into NSW's complex health system. It is difficult for IMGs to settle with no standard package of relocation/visa payment or housing on arrival, and it is very expensive for many IMGs arriving from countries with a very different financial situation to Australia. HNELHD has implemented initiatives to improve IMGs' introduction to Australia and HNELHD. For example, all IMGs are offered a 3-day orientation, which are held three times per annum, and are offered the opportunity to attend the Hospital

Non-Specialist Education Program which is a program supported by NSW Health Education and Training Institute (**HETI**).

35. Significantly, in December 2024, HNELHD will commence a supportive introductory program with six weeks of supernumerary training, education, buddying and orientation before new IMGs commence their roles in February 2025. There are 20 IMGs allocated to the initial program.

36. HNELHD has also employed two Medical Concierge Settlement Service officers at Tamworth and Taree to improve the experience for IMGs resettling in Australia and HNELHD. The concierge service is mainly to provide a service to IMGs coming into senior roles, but we will develop information for our JMO Networks to provide to JMOs arriving from overseas. The assistance provided includes receiving a welcome from the airport, assisting with accommodation and provisions on arrival. This is an individualised service.

37. As a LHD with a high IMG workforce, HNELHD dedicates a large amount of funding and administrative time to assist IMGs in relocating and integrating into HNELHD. This includes assistance with visas, training and welcome initiatives.

(iv) Senior Medical Staff

38. Facilities which attract a high Full- time Equivalent (**FTE**) for senior medical staff also attract a high FTE of JMOs due to the need to meet supervision requirements and also because the facilities are often large, busier and metropolitan sites. Inequity in FTE means those working at smaller sites, often with less JMO support, are on-call more often and also have a higher reliance on locums. Having a minimum standard of expected FTE for on-call rosters would make positions more attractive as younger specialists are no longer willing or wanting to work arduous on call rosters. A minimum of 1 in 4 on-call would seem reasonable, as recommended by the Henry Review with respect to paediatric on-call rosters.

39. One of the primary challenges in recruiting and retaining senior medical staff is remuneration. Our main shortage areas are Obstetrics, Anaesthetics, Emergency, Psychiatry, and Radiology. As stated above, HNELHD medical staff are leaving NSW to obtain more competitive remuneration interstate or leaving to be a locum within NSW where some have access to exorbitant rates.

<u>General Practitioner (**GP**) Visiting Medical Officers</u>

40. HNELHD's GP VMO staff generally work at HNELHD's district hospitals. NSW Health's fee-for-service model often does not work well for these sites as they have lower activity, reducing remuneration for VMOs attending the hospital, compared to the income they would otherwise receive from their private practice (and in the context of the fixed costs of running their private practice while attending the hospital). I have heard many GPs leave the State's health system because of remuneration packages that are not viable for them. I consider these facilities would be better suited to sessional contracts to give the VMOs guaranteed income. Whilst it is more expensive for facilities to offer sessional contracts to VMOs at low activity sites, many of our facilities such as Narrabri and Moree have been moving to sessional VMO contracts to maintain coverage and retain staff.

41. I believe that greater collaboration between NSW Health and the Federal Government, enabling a model of work for GPs across our facilities and private practice, would assist with recruiting additional GPs to our facilities. I also think offering a diverse practice between primary health and state-based health, is what many GPs are looking for.

42. The GP employment system is also very complex, with two separate colleges and training being conducted in our facilities but with no ongoing employment. Various exemptions and rural fee differences are also added complexities. In my view, reducing these complexities would improve the GP workforce by making it easier for GPs to work across different facilities. The GP workforce at NSW Health facilities would also be improved if there was more GP exposure as a student and as a JMO.

43. On 22 March 2024, the HNELHD's Medical Directorate hosted a forum in Tamworth to discuss strategies for addressing HNELHD's rural and regional medical workforce shortages and develop a sustainable workforce to serve rural communities. Ninety people attended the forum including rural GPs, rural health services managers, colleagues from the MOH, HETI, the Royal Australian College of General Practitioners (**RACGP**), Australian College of Rural and Remote Medicine (**ACRRM**), Hunter New England Primary Health Network, UON, and the UNE. The forum considered pathways from medical school into a rural health training pathway, how we could address our shortages in district hospitals and finally how we can address need in our regional hospitals.

44. From this forum we have worked on opportunities for students and have been in discussion with UNE and UON. We are engaged in the John Flynn Model, Single Employer Model and Rural Doctors Network student placements. We have also started looking at remuneration packages in some of our district hospitals and have attended

over 30 hospital sites. We have also considered implementing a GP rural DMS role to complement the current rural DMS, a specialist in one of our regional hospitals, and support rural GPs working at HNELHD facilities. We have also been successful in recruiting in our regional hospitals by working with agencies to recruit as well as registering positions as AON, referred to above.

(v) Locums

45. HNELHD's locum rate of payment is generally consistent across the District, however, it does vary and depends on criticality. There have been instances where HNELHD facilities have been competing against each other for a locum or against another LHD's facility in NSW. The rates vary depending on size/activity of hospital. If a locum cannot be identified, virtual Emergency Department (**ED**) services are used and have been highly successful, though staff do report preferring "boots on the ground" and staff report feeling more supported having medical staff in our facilities at all times.

46. HNELHD is heavily reliant on locums due to significant shortages in our senior medical staff workforce, including in Obstetrics, ED and Anaesthetics. At times our facilities have difficulties providing consistent obstetrics, anaesthetics or theatre access because of workforce shortages including nursing shortages. When HNELHD cannot provide medical staff in our hospitals we have detailed processes followed to delegate care within our network of hospitals. There have been times where we cannot get ED staff to our regional hospitals including Armidale and Manning. Armidale Hospital has significant senior staff shortages leading to hospital services going on bypass at times. This is done with strict attention to quality and safety at all times, with extensive communication processes in place.

47. Other challenges associated with the use of locums include:

    a. the varying quality of locum staff.

    b. many permanent staff in towns feel locum staff fly in and out and may not contribute further than providing a clinical service. For example, not always teaching, doing administrative tasks or improving quality; and

    c. there is resentment that locums get more money, accommodation and often transport provided, above rates provided to local permanent staff.

48. The workforce initiatives mentioned in my statement have stabilised locum usage. Whilst these initiatives are still in their early stages, it appears that less JMOs are leaving their positions to locum elsewhere and many have returned to training schemes.

Dr Paul Craven	Witness: Brad Webb
6 September 2024	6 September 2024