# Special Commission of Inquiry into Healthcare Funding

## Statement of Rebecca Nogajski

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| **Name:** | Rebecca Nogajski |
| **Professional address:** | Western Sydney Local Health District, Westmead Hospital, Darcy Road, Westmead 2145 |
| **Occupation:** | Executive Director Medical Services, Western Sydney 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 as a witness. The statement is true to the best of my knowledge and belief.

2. This statement is provided in response to a letter of 23 May 2024 issued to the Crown Solicitor's Office and also Issues Paper1/24, and addresses the topics set out in those documents relevant to my role.

## A. INTRODUCTION

3. My name is Rebecca (Bec) Nogajski. I am the Executive Director Medical Services (**EDMS**) of Western Sydney Local Health District (**WSLHD**), a role I have held since February 2022, having previously acted in the role for an extended period in 2021. I also hold the position of Clinical Network Director of Paediatrics for WSLHD. I was previously the Director of Paediatrics at WSLHD. A copy of my curriculum vitae is exhibited to this statement (**MOH.0010.0317.0001**)**.** I am making this statement in my capacity as EDMS.

4. In my role as EDMS, I am a member of the WSLHD Executive Team and I provide overall leadership and oversight of matters related to the governance and management of the medical workforce across WSLHD including Westmead, Auburn, Blacktown and Mount Druitt hospital sites as well as Mental Health, Drug and Alcohol, and Integrated and Community Health services. In this role I am responsible for the delivery of professional and clinical leadership in the strategic and operational management of medical services across WSLHD.

5. As EDMS, I am the professional lead for all doctors across WSLHD. I am responsible for ensuring the systems and processes for recruitment of the WSLHD medical workforce, and I oversee the annual medical recruitment (**AMR**) of Junior Medical Officers (**JMOs**). The AMR includes the recruitment of staff to training positions and to unaccredited junior medical officer roles.

6. Since my commencement as EDMS, I have extended the scope of the role to provide increased oversight over the management of WSLHD's Medical College Accreditation, including:
   a. maintenance of standards in line with College requirements;
   b. responding to and acting on feedback received through College assessments; and
   c. proactively identifying areas where challenges are emerging that may place accreditation status at risk.

## B. THE CURRENT NUMBER, DISTRIBUTION AND ADEQUACY OF SPECIALIST DOCTORS WITHIN WSLHD

7. WSLHD employs around 480 full time equivalent (**FTE**) staff specialists and engages around 550 Visiting Medical Officers (**VMOs**). The hours of the VMOs vary greatly, with some VMOs working close to full time and others with no regular hours allocated. The staff specialists and VMOs work across about 45 departments/speciality areas and are distributed across the four hospitals of WSLHD, as well as the service areas of Mental Health, Drug Health and Integrated and Community Health. Some of these doctors have an appointment at more than one WSLHD facility. These numbers are relatively stable year to year.

8. WSLHD engages VMOs under the terms of the *Visiting Practitioner Appointments in the NSW Public Health System* Policy Directive PD2016_052. A copy of this Policy Directive is exhibited to this statement (**MOH.0011.0004.0001**). Section 15.3.4 outlines the types of service contracts for VMOs. It states "[t]he type of VMO service contract that is utilised depends on the VMO remuneration arrangements applicable at the facility at which the services are provided and the speciality involved i.e. sessional, fee for service, election of choice or Rural Doctors Settlement Package fee for service." The last form of service contract does not apply to any of the staff working at WSLHD hospitals. The contracts adopt standard templates provided by NSW Health.

9. As set out in the Policy Directive, the applicable arrangements (session or fee for services) are determined by the facility peer group. Peer Group A facilities are sessional only, while Peer Group B and C1 facilities are able to elect the contract type offered. Westmead Hospital is Peer Group A, Blacktown Hospital is Peer Group B, Mount Druitt Hospital and Auburn Hospitals are Peer Group C1.

10. “Peer Group” refers to the systems of categorising public hospitals are based on size, role in the system, and geographical location (i.e. rural or metropolitan area). This is used for reporting and service planning at a state level. The peer grouping criteria for NSW are set out in *NSW Hospital Peer Groups 2016* IB2016_013. A copy of IB2016_013 is exhibited to this statement (**MOH.0011.0003.0001**).

11. WSLHD appoints the majority of our VMOs to a five-year contract cycle (the quinquennium), with ad hoc and fixed term recruitment occurring as needed within this cycle.

12. VMOs are used most commonly in WSLHD in surgical specialities, as well as areas such as anaesthetics and Emergency. Auburn Hospital uses VMOs as the primary consultant model in a broader range of departments.. Mental Health has recently shifted to converting some staff specialist positions to VMO positions in response to market forces. This is not the preferred model for this service for WSLHD, however the VMOs are providing important service provision. Access indicators such as waiting times in Emergency Departments and outpatient departments, as well as surgical waiting lists show that there is unmet demand for services in Western Sydney. The problem of unmet demand does not derive only from the number of specialists, it also involves the adequacy of wrap around services and roles (for example, nursing, allied health) and available infrastructure. Part of this challenge is that the current NSW medical awards are not structured to support 24/7 service delivery in our hospitals. Current awards seem to be based on a “business hours” services, but hospitals run 24 hours a day.

13. Providing care in a District like WSLHD is a different exercise than might be required in other areas of Sydney. WSLHD is a vibrant and diverse community. We have a large proportion of priority populations including a large migrant community and a large Aboriginal community. The social demographics vary widely across the LHD, with pockets of extreme disadvantage and low levels of health literacy. This increases the complexity and amount of the work performed by WSLHD specialist doctors.

14. Long term future workforce planning is quite challenging. Future needs are looked at for individual departments, but our focus is generally on meeting immediate service delivery demands within the available resources, which does not leave a lot of scope to look more long term and look at future workforce needs modelling or predictions approach. I believe the Ministry of Health (**MOH**) is looking to do

more in this space which I think is important. For this to be effective it needs to be at a state or even national level and work with education providers.

15. The specific specialties which face shortages, making recruitment to vacant positions difficult within WSLHD facilities are generally reflective of the shortages faced by facilities across NSW and Australia. For example, it is currently difficult to recruit psychiatrists and anaesthetists. WSLHD is competing against private hospitals and private practice clinics which can offer a much higher level of income and a lower acuity of the patients needing care. The award for medical officers in NSW is also not seen as competitive against other states, both for junior and senior doctors.

16. Agency Locum doctors have an important role in filling immediate workforce gaps. In WSLHD, these are mainly used for junior medical roles. There are also risks associated with the use of locums. These include:

    a. Locums may not be familiar with local processes and protocols and are unfamiliar with the teams they work with.

    b. Locums are premium labour and add significant costs. Although *Remuneration Rates for non-specialist medical staff – short term/casual (locum)* Policy Directive PD2012_046 sets rates for locum engagements, it has not been updated for some time and the prescribed rates are well below market expectations. A copy of PD2012_046 is exhibited to this statement (**MOH.0011.0005.0001**).

    c. The hourly rate of locums is negotiated between the locum agency and respective the employing LHD, which means that different LHDs and hospitals are competing against each other for available staff. This drives up rates and can have one LHD, or even hospitals within the same LHD, played off against the other.

17. The use of locums also creates the situation where WSLHD staff are being paid considerably less per shift than the locums working alongside them. This is problematic when the use of locums becomes embedded in a workforce. We have set up and are continuing to work on internal processes to make sure that there is transparency and good governance around how and when we use locums.

## C. THE CURRENT NUMBER, DISTRIBUTION AND ADEQUACY OF SPECIALIST TRAINING POSITIONS, DOCTORS UNDERTAKING SPECIALIST TRAINING AND SPECIALISTS ABLE TO SUPERVISE DOCTORS UNDERTAKING SPECIALIST TRAINING WITHIN WSLHD

18. WSLHD is currently funded for around 1,000 FTE JMOs. These are spread across the facilities and services covering the various departments and specialities. This number does not change much year to year, with increases of a few FTE positions based on enhancements, or when there is a specific funding allocation made through NSW Health or other programs.

19. The challenges faced by WSLHD in terms of staff numbers, recruiting and retaining trainee specialists is broadly the same as the challenges faced for specialist doctors. Challenges include:

    a. The number of trainees (as well as unaccredited JMOs and Career Medical Officers) that WSLHD can employ is limited primarily by the available budget. Within this, there are also limitations placed by the number of specialists needed to supervise (ratios) or the numbers of positions that a College is willing to accredit.

    b. Supervision of trainees is provided by specialist staff outlined above, although each Medical Training College has their own requirements for supervisors (such as required training). The requirements of some specialist training Colleges and programs are increasing and it is consequently becoming more time consuming for specialist doctors to supervise trainees. Providing high quality training, as well as mentoring and professional support is a key factor to both the attraction and retention of the current doctors in training and in building the connections that will make them want to return to work in WSLHD as future specialists.

    c. Our workforce data shows that many areas are routinely rostering overtime, and that un-rostered overtime is occurring frequently. There is also a high amount of accrued leave for the JMO staff.

    d. As to recruiting, some specialities are easier to fill than others. There are multiple factors that contribute to the variation. In some specialities, it seems that there are not enough trainees joining the training program. For example, currently intensive care medicine is not a popular training choice for JMOs, and

this is reflected in recruitment efforts across the state with vacancies. In other areas, WSLHD rates low on “preferencing” where there is a centralised recruitment process.

20. The Health Education and Training Institute (**HETI**) takes a role similar to a Medical Training College for Post Graduate Year 1 & 2 (PGY1/ PGY2) doctors (also known as interns). This involves a centralised recruitment and allocation process and accreditation of sites as training providers. The systems around this are quite robust and I think for the most part function well.

21. While we cannot easily increase the number of funded positions either locally or at a NSW Health level, WSLHD is working on how we attract and keep JMOs to our hospitals. These initiatives include:

    a. making improvements to recruitment processes including ensuring timeliness of advertising positions and ensuring recruitment panels are appropriately composed and are working efficiently;

    b. improving orientation programs for new trainees;

    c. running information sessions and Roadshows and encouraging self-promotion by departments and facilities;

    d. ensuring staff members are paid for the work they do and receive their entitlements including payment of un-rostered over time and allowance, while working to reduce the need for overtime where possible; and

    e. focusing on safe and reasonable working hours and supporting wellbeing including access to leave, training and education and rostering and promoting the NSW Health CORE values.

## D. RECRUITMENT OF INTERNATIONALLY TRAINED DOCTORS

22. WSLHD frequently recruits International Medical Graduates (**IMGs**) to fill JMO positions. Recruiting IMGs causes delays to planned start dates as these doctors need to go through immigration, registration and College recognition processes as well as move to Australia before they can start work. There is also a period of adjustment to the Australian medical environment and NSW Health public health system (IT systems, local procedures and culture) where these doctors need higher levels of support from their supervisors and colleagues.

23. The IMGs that WSLHD recruits to JMO positions are generally applicants through the statewide Annual Medical Recruitment campaign or ad hoc recruitment, not through specifically targeted overseas recruitment campaigns. These recruitment actions, including management of any associated visa requirements are managed in accordance with *Recruitment and Selection of Staff to the NSW Health Service* NSW Health Policy Directive:*PD2023_024*. A copy of PD2023_024 is exhibited to this statement (**MOH.0010.0064.0001**).

24. Applicants are sometimes received from candidates for Staff Specialist positions from overseas candidates also, again being managed within PD2023_024. Sometimes a role might be advertised specially to attracted overseas candidates where there has been unsuccessful recruitment attempts locally.

25. A strategy that WSLHD has implemented both to address recruitment challenges and to support the adaptation of IMGs to the NSW Health system is the "Workplace Based Assessment" (**WBA**) program. This is an alternative to the Australian Medical Council (**AMC**) Clinical Examination that IMGs can access to obtain their registration in Australia and practise safely within the Australian health care environment and cultural setting. WBA is additional to normal supervision requirements that apply to all IMGs and doctors-in-training.

26. The first WSLHD WBA commenced on 6 November 2023 and is due to conclude on 8 November 2024. The program is conducted at Blacktown and Mount Druitt Hospitals (**BMDH**) within the Emergency Department. 29 applications were received for the ten available places.

27. Recruitment to this program is via Expression of Interest to existing employees for WSLHD, making it an incentive for candidates to take up WSLHD positions.

28. The program has been a successful recruitment strategy in its first year and has helped reduce the number of vacancies in the department and has been well received by participants in helping them transfer into and adjust to the NSW Health system. Successfully implementing this program has taken a lot of work from staff within their existing roles. The program's long term viability will need to be considered in this context also.

## E. ACCREDICATION TO PROVIDE SPECIALIST TRAINING BY THE COLLEGES AND THE AVAILABILITY OF TRAINING POSITIONS AT WSLHD

29. The process of obtaining accreditation to provide specialist training by the Colleges is fairly straightforward. The Colleges provide proformas to fill in which address the criteria they set for their training programs. This includes supervision arrangements, teaching requirements and access to appropriate clinical experiences. Some Colleges, such as the Royal Australasian College of Physicians (**RACP**), require supervisors to complete training through the College. The application then goes to the relevant College for approval. It is up to the individual Colleges to determine the number of positions they accredit for training in their speciality.

30. The decision to seek new accreditations in WSLHD is made at a district level based on recommendations and information from department and facility leaders. This does not happen often as WSLHD is well established as a training facility for the majority of our speciality areas.

31. I am aware that some Colleges, such as the Royal Australian College of Surgeons have caps on the number of trainees that they will accept into the program. I am not able to speak to the decision making or planning undertaken within the Colleges on how those numbers are decided.

32. The number of accredited training positions available in WSLHD is more limited by our available budget to fund them, than the number of accredited training positions that the Colleges will support. Any increases that are made to the number of accredited training positions are very small year to year.

33. The other factor that may limit the number of trainees that WSLHD has in a department or speciality, is the need to maintain a set ratio of trainees to consultant staff to provide supervision.

34. For currently accredited departments, the day to day responsibility for making sure that the College accreditation standards are maintained is managed at a facility level. I have oversight over this process though the Medical Training Accreditation and Governance Committee (**MTaG**). MTaG was established to improve oversight and governance of the College accreditation process and is where accreditation issues and risks are discussed. MTaG meetings are held monthly and are attended by the General Managers and Directors of Medical Services of the facilities as well as other key medical leads.

35. Under the processes set up as part of MTaG I have oversight of formal correspondence to the Colleges regarding site inspections and any recommendations or conditions that have been made. I become directly involved in the discussions with the Colleges where there are accreditation issues with higher levels of risk, or where the negotiations are not going well, or where there are unrealistic timeframes or conditions. I also keep the Chief Executive of WSLHD informed of accreditation risks and achievements.

36. In August 2021, the Royal Australian and New Zealand College of Radiologists (**RANZCR**) withdrew their accreditation at Westmead Hospital. I consider there were some valid concerns raised by RANCZR which needed to be addressed. Some recommended measures were not reasonably able to be implemented, such as significantly increasing the numbers of specialist staff employed.

37. I was not directly involved in accreditation management in the period leading up to RANZCR withdrawing accreditation and had only been acting in the EDMS role for a short period of time prior to its withdrawal, so my view is retrospective. With the benefit of that hindsight, I consider there were opportunities to improve communication pathways both within WSLHD, and with the RANZCR, and also improve the co-ordination and management of the responses to the recommendations. I was closely involved in the management of the loss of the accreditation.

38. The biggest concern to me about the withdrawal of accreditation for Radiology training was that it occurred mid-term, meaning that the trainees currently in roles at Westmead Hospital would not have their training recognised for the remainder of their contracts. The uncertainty of this was stressful for the trainees and everyone involved. This is something I have discussed directly with the College. We were able to negotiate a Memorandum of Understanding (**MoU**) with the College that allowed those trainees remaining with Westmead to have their training recognised in line with the work they had undertaken to minimise that impact. Executed copies of the MoU are exhibited to this statement (**MOH.0010.0296.0001** and **MOH.0010.0295.0001**). Rebuilding strong communication and focussing on the shared aim of supporting trainees was key to both negotiating a MoU to reduce the impact on trainees, and also regaining accreditation. This was a two-way engagement with WSLHD and senior College representatives.

39. The process of obtaining accreditation following withdrawal of accreditation by a College is less straightforward than gaining it in the first place. The withdrawal of accreditation by RANZCR at Westmead Hospital is the only time I have been directly involved in this process. The process requires back and forth negotiation and communication regarding the issues raised and a discussion as to the practicality of implementing the recommendations. The process including the implementation of recommendations, and reapplying for accreditation takes a minimum of around 6 to 12 months. If re-accreditation is successful, it is generally given provisionally for a period of 12 months. As EDMS, I have used this experience to improve the way Medical College Accreditation is managed, and how WSLHD manages relationships with Colleges which can be seen in the establishment of MTaG.

## F. RECRUITMENT AND RETENTION OF THE HEALTH WORKFORCE IN WSLHD

40. Recruit of junior medical staff in WSLHD happens through the state-wide annual medical recruitment (**AMR**). This is a large-scale process and has advantages in making sure that all LHDs are advertising and making offers at the same time. It is challenging in a workload sense for the recruitment staff as it is a big process with tight timeframes. From the point of view of both recruitment staff and doctors applying for roles, it is quite labour intensive. For example, a doctor applying for multiple roles uploads the same documents each time, and the recruiting LHDs run the same checks. NSW Health are working to streamline some of this which is positive.

41. Outside of the AMR, ad hoc recruitment happens at a local level, still under the guidance of NSW Health policy.

42. Senior Medical Staff recruitment is managed centrally for WSLHD through our Senior Medical and Dental Recruitment Unit (**SMADR**). This team works to make sure that recruitment and credentialing policies are upheld. Compliance with these processes is really important. I think there are opportunities for some reduction of duplication when people are appointed across LHDs.

## G. CONSULTATION WITH THE HEALTH WORKFORCE IN WSLHD

43. Consultation and engagement with the doctors of WSLHD happens through various means. Doctors (including VMOs) are included in the annual People Matters Employee Survey (**PMES**) along with all other staff, but have a low

response rate. I see more meaningful levels of response from junior medical officers to specific surveys done across the state, such as the annual Medical Training Survey, which is supported by many of the Training Colleges and as well as the Australian Medical Association (**AMA**).

44. The facility and Executive Medical Staff Councils (**MSC**) provide a formal structure for engagement and consultation. This is an important structure to have. The role of the MSC can be a complex one as it is a small number of doctors tasked with representing their peers, who will have a wide range of views on any given topic. It is important that other engagement approaches are also used. Each WSLHD facility has a Clinical Council which is another structure for consultation. Clinical Councils are multi - disciplinary which also makes this an important forum.

## H. PROCESSES AND PROCEDURES FOR MANAGING COMPLAINTS AND DISPUTES AT WSLHD

45. WSLHD complies with NSW Health's policies and procedures for managing complaints and disputes relating to medical staff. Key documents include:

    a. *Prevention and Management of Bullying in NSW Health* Policy Directive PD2021_030. A copy of this Policy Directive is exhibited to this statement (**MOH.0002.0087.0001**);

    b. *Resolving Workplace Grievances* Policy Directive PD2016_046. A copy of this Policy Directive is exhibited to this statement (**MOH.0002.0047.0001**);

    c. *Prevention and Management of Unacceptable Workplace Behaviours in NSW Health – JMO Module* Policy Directive PD2021_031. A copy of this Policy Directive is exhibited to this statement (**MOH.0002.0087.0001**); and

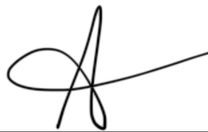
    d. *Managing Complaints and Concerns about Clinicians* (MCCC) Policy Directive PD 2018_032. A copy of this Policy Directive is exhibited to this statement (**MOH.9999.0933.0001**).

46. Raising concerns or complaints against more senior members of staff is always difficult. This is intensified for junior doctors where, for example, a supervisor has direct influence on your access to training and experience opportunities, writes the term reports that determine your progress and may be a senior member of the College that you are working to be accepted into as a Fellow.

47. It is important that lines of support and escalation of concerns are available outside the lines supervision or departmental reporting lines.

48. Internally we make sure that all JMO orientation sessions include information on those to whom any concerns should be raised. This includes the JMO Managers, the Director of Pre-vocational Training and Education (**DPET**) and Directors of Medical Services. Each site has an appointed JMO Complaints Officer (usually the JMO Manager) who can receive and assist the referral of complaints.

49. Training Colleges (including HETI) also have mechanisms for providing feedback and their accreditation assessments include criteria around providing a safe and effective training environment. In some cases, trainees raise concerns to College assessors as part of an accreditation site visit as this gives a mechanism that is separate to their employers. It is important for us as the LHD that when this happens, the College gives us enough information so that we are able to respond to the concerns.



Rebecca Nogajski

16/7/24

Date

Witness:

16/7/24

Date