Special Commission of Inquiry into Healthcare Funding

Statement of Dr Nicholas Spooner

Name: Dr Nicholas Spooner

Occupation: Director of Emergency Medicine, 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. The statement is true to the best of my knowledge and belief.

A. My Role

3. I am a Staff Specialist Emergency Physician within the Central Coast Local Health District (**CCLHD**). I was appointed a Staff Specialist in 2018 or 2019. I am also a Fellow of the Australian College for Emergency Medicine (**ACEM**). Prior to becoming a Staff Specialist, I completed the bulk of my training in the CCLHD. I also undertook locum work across NSW and worked with the Westpac Rescue Helicopter Service.

4. I am currently the Director of Emergency Medicine at Wyong Hospital. I have been in this position since early 2023. For several years prior to that, I was the Deputy Director of Emergency Medicine at Wyong Hospital.

5. I am also currently the President of the Australian Salaried Medical Officers' Federation (**ASMOF**). I was elected to this position at the end of May 2024, and I was officially appointed to this position in late June 2024. My prior involvement with ASMOF was as a member.

6. I am also a Conjoint Lecturer at the University of Newcastle.

7. With the exception of my personal experiences at Wyong Hospital, this statement reflects the views of ASMOF as well as my own.

B. Current Workforce Issues

8. The current workforce model in NSW which utilises Staff Specialists, Visiting Medical Officers (**VMOs**) and locum staff is outdated and is regularly unable to provide a sufficient workforce to meet current staffing levels. It is ASMOF's position that this is largely due to issues with the *Staff Specialists (State) Award 2022* (**the Award**), and difficulties in attracting and retaining staff.

9. Despite determined attempts to attract and retain staff to fill current positions (including the engaging of VMOs and locum staff), there are multiple full-time equivalent (**FTE**) positions vacant, and multiple shifts every day that are short of staff.

10. For example, in the middle of the COVID-19 pandemic, in the Emergency Department (**ED**) at Wyong Hospital there were sometimes up to 13 vacancies in the medical staff roster on any one day because we could not find people to fill these gaps.

11. Currently, we have 10 FTE vacancies at the "middle grade" (i.e. registrars) in the ED, which translates to four to five vacancies in our rosters per day. In addition, we are one or two FTE consultants short. I understand that in the Gosford Hospital ED, there are 10 FTE vacant registrar positions. I also understand that CCLHD is also 4.5 FTE short in obstetrics and gynaecology. I understand that there are other significant staff shortfalls across the system. For instance, I am aware that ASMOF is in discussion with the Ministry of Health regarding a 50 per cent shortfall in psychiatrists in the Western Sydney Local Health District.

12. The current workforce model heavily relies on VMOs and locums to try to fill workforce gaps. For example, in a four-week period in around May 2024, we had 45 vacant consultant shifts within the medical staff roster at the Wyong Hospital ED that we offered to VMOs and locum staff. Of these shifts, we were able to fill just over half of these shifts with either VMOs or locums, while the other shifts remained vacant.

13. In the ED at Wyong Hospital we try to manage the staffing shortages and gaps in rosters in ED by continually triaging patients and attending to the most urgent and life-threatening conditions. Although this assists the ED to continue to function, and ensures that urgent patients receive care, this means that patients with less acute conditions are required to wait

for longer periods which can lead to frustration among patients and staff. This also means that we are not delivering the expected high-level services we are supposed to provide to people in NSW.

14. To obtain locum staff, in addition to the remuneration paid to the clinician, hospitals are required to pay for their travel and accommodation, as well as any fee charged by a locum agency. Junior medical staff can only be engaged as a locum through a locum agency. Consultants do not have to go through an agency, however, sometimes do so. My understanding is that if the agency and travel/accommodation costs are put to one side, it generally costs hospitals the same amount of money to have a locum as a VMO emergency consultant on a sessional rate.

15. There are also inefficiencies in the use of locum staff. Junior doctors are not permitted to work as a locum within their own LHD, which means to work as a locum they are required to seek work in another LHD. Whilst a junior doctor is able to undertake additional work within their own LHD, this is on a casual basis, and they are paid at rates much lower than are paid to locum (and is therefore less attractive). In my view, it would be more efficient if clinicians undertaking additional work remained in their own LHD as they already have the relevant knowledge of how things work, such as applicable procedures and who to call for assistance, and can commence work immediately without going through an "onboarding" process. In addition, although the locum rate is higher, there would often be savings in the travel and accommodation costs associated with locums from another LHD.

16. Locums are also challenging to manage in terms of professional development and performance management as they generally do not stay for a long period of time. They also do not contribute to the department in terms of administration and clinical governance or (in the case of senior doctors) teaching time.

17. There are reducing numbers of Staff Specialists in the system as more clinicians are engaged as VMOs (or failing that locums).

18. My understanding is that that the long term financial cost to the system of a VMO is not significantly different to that of a Staff Specialist if it is assumed that:

a. Staff Specialists are able to take all of their entitlements under the Award including annual leave, sick leave and Training, Education and Study Leave (**TESL**).
b. VMOs are retained to undertake only clinical work.

19. Therefore it is not necessarily financially beneficial in the long term for LHDs to employ staff under one arrangement or another, however, more of the cost for a VMO is "up front" whilst some Staff Specialist costs may be delayed (such as annual leave that is not taken and carried over), or not incurred because the entitlement is lost (such as often occurs in the case of unused TESL).

20. There can however be other differences. Staff Specialists are required to undertake clinical governance including mortality and morbidity reviews, attending meetings and committees, and discussing and contributing to guidelines. Although VMOs can be engaged to run clinical governance, it is expensive to do so, and VMOs tend to be engaged primarily by hospitals to carry out clinical work, and not engaged to provide clinical governance. This is problematic as clinical governance is fundamental to improving the public health system. However, VMOs have a valuable contribution to make, particularly in filling vacancies when hospitals cannot engage permanent staff, and they provide important clinical services. I also recognise that in some specialisations and locations VMOs do undertake clinical governance, and in some cases head hospital departments.

21. Workforce shortages reduce the morale of existing staff, erode workplace culture and impact on service delivery. Although these challenges existed prior to COVID-19, they have increased since the pandemic as there is a growing demand, relentless under resourcing and understaffing. Staff are often fatigued whilst on shift, which is not always well managed by hospitals. As work intensifies, it is more difficult for staff to take their breaks which leads to a decline in productivity and can lead to errors in their work. Such working conditions over a long period leads to clinicians feeling burnt out and undervalued, which makes it difficult to attract and retain medical and nursing staff, not only in EDs but other areas. These challenges are further exacerbated in rural and remote areas, including greater difficulty in recruiting staff due to a variety of reasons.

C. Workforce Models

22. Workforce plans within NSW Health are often embodied in strategic plans and budgets. My understanding is that these models are generally decided upon by the LHD. My experience is that these workforce models are very conservative.

23. In around 2021 to 2022, I asked the Wyong Hospital Executive whether there were any workforce models being used based on predictive modelling, as if we could determine what services required more resources, we could appropriately allocate staff to those services. While the Executive were interested in adopting predictive modelling, I was told that it was not currently in use. I understand it is still not being used.

24. The relevant data which would be required by LHDs to undertake predictive workforce modelling, including estimations of population growth, socio-economic status, ED presentations and the number of children and adult presentations, is available. There needs to be financial investment to implement this type of modelling, and I believe it is viewed as something of a novel concept by NSW Health.

25. In the context of emergency medicine, ACEM has recommended staffing models. For example, ACEM's *G23 Guidelines on Constructing and Retaining a Senior Emergency Medicine Workforce* (**G23 Guidelines**) **(SCI.0011.0242.0001)** recommends minimum medical staffing levels for emergency departments using numbers of emergency presentations per year to determine the minimum number of consultants (FACEMs) and junior doctors required to be rostered on for each shift to provide safe patient care.

26. For the most part, the model suggested by ACEM is not currently being implemented in NSW. For example, the G23 Guidelines suggest that for a hospital with 65,000 to 80,000 ED presentations per annum, during the day shift there should be 16 medical staff in total rostered on, comprised of five emergency consultants (FACEMS), three advanced trainees, four intermediate trainees and four junior medical officers (**JMOs**). In comparison, at Wyong Hospital, which has around 80,000 ED presentations per annum, on a day shift our roster provides for a total of 11 staff including two consultants. In addition, as detailed above, we currently experience an inability to fill all of the shifts on the roster.

27. The current staffing model at Wyong Hospital ED was developed in 2018. We are currently seeking enhancement of this model to be more representative of appropriate staffing levels. In anticipation of this enhancement, it will be highlighted to the Executive that we are currently having to fill vacancies using VMO and locum staff, and that permanent staff should be recruited if possible.

D. The Staff Specialist Award

28. Staff Specialists working in the public health system fall under the *Staff Specialists (State) Award 2022* (**the Award**). It is the position of ASMOF (with which I agree) that this award is out of date in regard to remuneration and other conditions, and that this creates challenges in attracting and retaining staff. I have spoken with other consultants who have relocated to work interstate for better award conditions and remuneration.

29. Remuneration for Staff Specialists under the Award is currently less than in any other Australian State or Territory. By around 2023, Staff Specialist awards in other Australian States and Territories had undergone reform to greater align them with modern practice, as well as to significantly increase remuneration. The Award in NSW is currently out of step compared to these awards. Even if the Award in NSW is reformed, Staff Specialist awards in other States and Territories are likely undergoing further review and change. In relation to remuneration, this is likely to mean would mean that the Award in NSW will fall further behind.

30. In terms of Award conditions, I will discuss a number of examples, although there are other conditions which myself and ASMOF believe need reform.

31. The Award is out of date with current practices, such as on-call work, which means that staff are not appropriately remunerated or valued for the work they do. In comparison, equivalent awards in other states have been updated to reflect these new work practices. This can impact on the attraction and retention of medical staff in NSW.

32. One example in other States and Territories is the provision within the relevant awards for time and funds for Staff Specialists to undertake TESL. In NSW, TESL entitlements currently sit outside the award which makes it difficult to ensure entitlements are taken and also means that it can theoretically be adjusted or modified without the approval of Staff Specialists

(although this has not occurred to date). It is ASMOF's position that making TESL part of the Award in NSW would better ensure Staff Specialists can undertake training and professional development in accordance with their entitlements.

33. Another example relates to overtime. There is currently no capacity in the Award for Staff Specialists to be remunerated for overtime work completed between midnight and 7am. For example, if I am on shift from 2pm to midnight and I need to work overtime due to clinical need, there is no way for me to be remunerated for that extra work. This can result in clinicians feeling undervalued. I note that in contrast junior staff can claim an overtime allowance.

34. In relation to being "on-call", Staff Specialists are required under the Award to undertake a "reasonable" amount of on-call work. As remuneration for this the Award provides for an 17.5% increase in pay for all Staff Specialists. This does not reflect modern work practices, or differences in on-call loads.

35. A Staff Specialist receives the same remuneration regardless of how much on-call work they are actually required to undertake. The same remuneration is received irrespective of whether a clinician is on-call one in five or one in ten. It is also the same whether the Staff Specialist provides advice over the telephone once during whilst on-call or attends the hospital for the entire on-call period to provide clinical care. Virtual care has also increased the amount of work a clinician completes whilst they are on-call as they are able to review patients remotely. At times, remote work can be equivalent to completing a full shift.

36. The on-call workload can vary depending on the hospital and whether it is in a metropolitan or a rural or remote area. It can also vary depending on the specialty. For example, it might be necessary for a paediatrician to attend the hospital frequently while they are on call as they are providing services to a vulnerable group and they may need to physically review the patient before making any decisions. As such, paediatricians are often essentially completing an entire shift while they are on-call. In comparison, others may feel more comfortable making decisions over the telephone and leaving in person clinical assessment to more junior doctors or until the morning.

37. The Award is also silent on various conditions relating to on-call work. For example, the Award does not clear specify how close you are required to be to the hospital during on-call

periods, rather requiring that a Staff Specialist be able to return to the hospital within a "reasonable" time. At my hospital there is an informal expectation that a clinician be within 30 minutes of the hospital whilst they are on-call.

38. Staff Specialists also find it difficult to use their leave and training entitlements. For example, under the Award, Staff Specialists are entitled to five weeks of annual leave per year. However, due to staff shortages and the volume work, it is often difficult to take leave which results in the accrual of leave. If a Staff Specialist has accrued a high number of leave hours, the LHD views this as a financial liability. Staff Specialists often receive emails from management requesting that they take their outstanding leave entitlements, however, the clinicians often cannot take the leave due to the pressures of work and staff shortages. There are also difficulties in taking TESL, however, those entitlements are lost if they are not used within a specified period.

39. As ED is a 24-hour, 7 day per week, 365 day per year service, it is not always possible for everyone who would want to take leave to do so at the same time, for example, in school holiday periods. My department tries to keep track of when staff previously took leave, and approve leave requests based on merit (for example, by giving priority to those who may not have been able to take leave on a previous occasion). Further, if requested leave is problematic for the department, I might ask staff to rearrange their shifts to assist with minimising roster gaps. This is somewhat effective in my department as we all are prepared to work cooperatively; however, it is only a short-term solution.

40. The Award is also silent on safe staffing levels to ensure the delivery of safe patient care. If we adopted a predictive model with minimum staffing levels, as described above, and know the amount of work that is likely to arise, we can predict a staffing profile which ensures safe staffing and improved service delivery to patients. ASMOF is attempting to articulate this issue in the present award reform negotiations.

41. In my view, changes to the Award will be pivotal in addressing current workforce challenges.

Signature: 

Name: Dr Nicholas Spooner

Date: Wednesday July 17th 2024