Special Commission of Inquiry into Healthcare Funding

Witness Statement

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. This statement is true to the best of my knowledge and belief.
3. This statement should be read in conjunction with my statement dated 17 July 2024.

A. Role

4. I am a Staff Specialist Emergency Physician within the Central Coast Local Health District (**CCLHD**). I was appointed a Staff Specialist in 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.
5. 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.
6. 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.
7. I am also a Conjoint Lecturer at the University of Newcastle.
8. This statement reflects the views of ASMOF as well as my own.

B. Maldistribution of Workforce

9. Having experienced workforce shortages in my substantive role in the CCLHD, I am aware that it is not necessary to go far from metropolitan Sydney to encounter workforce challenges like those experienced in rural and regional facilities. Such challenges include difficulties recruiting

and retaining staff, difficulties filling vacancies in rosters, and reliance on a temporary workforce. Whilst the CCLHD experiences these challenges to an extent, the degree of such challenges worsens as facilities become increasingly more rural and remote.

10. To overcome the maldistribution issue, there needs to be a strong training pipeline which can produce the number of medical officers to meet the needs of each rural and regional community into the future. In my view, this requires the healthcare workforce, starting at the intern level and progressing up to specialist roles, to have training opportunities in rural and regional communities, and for those training opportunities to be of a sufficient duration to enable staff to be embedded in the community and adopt that location as part of their ethos. Whilst some degree of attrition is to be expected, workers who develop a sense of familiarity and comfort in a location are more likely to stay in that place, particularly when compared to casual staff.
11. As discussed in further detail below in section "E", recruiting and retention would certainly be bolstered by an award that is better able to generate the required number of doctors required to fill vacant positions.
12. Acknowledging that efficient and effective training pathways may take some time to develop, there is a shorter-term need for mechanisms which support regional LHDs and facilities to attract and retain staff in the way those regions see most fit. For example, in my role as Director of Emergency Medicine at Wyong Hospital, I often run into the barrier of the *Staff Specialists (State) Award 2022* (**the Award**) and the constraints it places on the attraction and retention incentives I can offer. In my view, it would be preferable if workforce incentives were not only prescribed by NSW Health or applicable industrial instruments, but instead could be supplemented by targeted incentives tailored by the people with the greatest knowledge of community needs, challenges and the potential viability of proposed incentives. It would be important, however, to place regulations on these incentives, so as not to promote an overly competitive market between LHDs and facilities.

13. There may also be scope to consider new mechanisms for distributing the health workforce to the areas of greatest need and without increasing the administrative and recruitment burden on regional healthcare facilities. For example, there may be a model by which large (and often desirable) hospital facilities in the Sydney metropolitan area offer doctors a substantive role on terms which also require the employee to work a fixed number of days per month in a rural or regional facility.
14. This mechanism could be beneficial in filling workforce gaps in rural and regional areas whilst promoting continuity of care within those regions. However, I foresee two key challenges to the mechanism operating as intended.
15. First, there would be a significant recurring cost in transporting and housing staff in the rural and regional locations where they were 'seconded'. This may limit the fiscal gains that would be otherwise provided for by this model and would not deter casualisation of the workforce in rural and regional areas. However, it may present an opportunity to explore more modern ways of working, including in the form of virtual care.
16. The other practical effect of requiring employees to work in remote and regional environments is that staff may be driven to other States and territories where no such compulsion exists, and where remuneration is better under their respective industrial instruments. Because the labour market is not in NSW's favour, I am concerned that NSW Health facilities would not have the bargaining power to implement that kind of requirement in its employment contracts.
17. Notwithstanding the above, if NSW Health could generate an effective mechanism supported by appropriate funding and legislation, it could be an interesting mechanism by which to address workforce maldistribution.

C. Reliance on Temporary Workforce

18. Related to the maldistribution of the workforce in rural and regional areas is the increasing reliance on temporary and casual staff to meet workforce deficits in those areas, and the resulting casualisation of the health workforce across the state.
19. The decasualisation of the health workforce is imperative from both a fiscal and clinical governance perspective. In particular, whilst casual and premium labour is not only very costly fiscally, the engagement of this kind of workforce also limits the efficiency of healthcare facilities because temporary staff cannot maintain continuity of care and do not contribute to the running of a facility outside of the clinical care provision.
20. In my view, it is far more efficient from both a fiscal and clinical governance perspective to employ staff specialists in place of locums. This is because salaried staff complete the vast majority of clinical governance, in addition to essential training and administration work, which is compensated through their ordinary salary. In saying this, I acknowledge that there are VMOs, particularly in rural and regional areas, who also provide training, administration, and rostering support. An assessment should be made of how this arrangement compares with the alternative of a staff specialist, who complete those duties as part of their everyday functions.
21. The lack of continuity of care is one of the greatest pitfalls of engaging casual staff as opposed to salaried staff, because of the implications for patient experience, safety and efficiency of care provided. In my view, continuity of care for patients is of fundamental importance because it fosters the building of patient relationships, minimises the wastage of time and resources in handing over patients between different casual staff, and eliminates the need for consistent onboarding of new staff.

D. Workforce Mobility

22. To improve the mobility of the health workforce to fill vacancies in other LHDs or work additional FTE where they have capacity to do so, it is necessary to revisit the processes and

frameworks relating to the accreditation of doctors and the requirements for working in multiple LHDs.

23. At present, each LHD is siloed and completes its own accreditation and onboarding process when a doctor applies to work in one of its facilities, even if that doctor has already been accredited in another LHD that also sits within NSW Health. The accreditation process generally involves supplying documentation which supports a doctor's medical qualifications and fitness to practice, including but not limited to proof of university graduation, fellowship acceptance, medical indemnity and working with children checks. Accreditation by one LHD does not automatically result in the recognition of that accreditation by any other LHD. In my experience, the accreditation process must be repeated in each LHD that you might work in.
24. The accreditation and onboarding process is time consuming and rigorous and limits the mobility of the workforce between local health districts, including where staff members are needed to fill vacancies. The frustration that clinicians feel embarking upon the accreditation process is one of the reasons locum agencies are so successful in recruiting doctors. Locum agencies will complete the accreditation process on behalf of doctors by collecting doctors' accreditation information and supporting material and sending that out to other LHDs as needed.
25. It is my understanding that the current siloed nature of the LHD accreditation processes stems from a resistance by LHDs to accept the accreditation information and decisions of other LHDs because there is a risk to patient care if that information is inaccurate. In my view, this leads to a poor use of resources and creates redundancy in workforce units, who spend significant amounts of time re-accrediting doctors who have already been accredited in other LHDs.
26. In my view, there would be significant benefit in a centralised State-based accreditation system to resolve this issue. A statewide accreditation model would remove the administrative burden for doctors to seek work in other LHDs, and NSW Health would see

economies of scale as well as faster access to staff who are available to fill vacancies. There would also benefits for portability of staff.

E. Reform of Industrial Awards

27. Staff Specialists working in the public health system fall under the Award, which is out of date in regard to remuneration and other conditions and creates challenges in attracting and retaining staff. Changes to the Award will be pivotal in addressing current workforce challenges.

28. In the past, ASMOF has indicated to the Ministry of Health and NSW Treasury during award bargaining processes that the deficiencies in the Award relating to human factors, work health safety, and wages impact attraction and retention of staff specialists. This has included comparison of the Award with similar instruments in other Australian states and territories and a demonstration that the Award in NSW is the worst in the country with respect to employment conditions and wages for staff specialists.

29. Negotiation of the Award was stalled under the previous government in relation to both wages and other conditions, including work health safety-related conditions. This was difficult for ASMOF and its members because it limited opportunities to renovate the Award and bring it up to speed with modern day work practices. I would speculate that the Award negotiations stalled because the government was unwilling to discuss wages, and therefore the opportunity was lost to negotiate other changes, including those which would recognise modern ways of working and the prevalence of virtual and on-call models of work.

30. It is the position of ASMOF (with which I agree) that there needs to be wholesale award reform by which the current Award is completely discarded and renegotiated from scratch. To my knowledge, this type of process has never been attempted, but for this “knock down and rebuild” renovation of the Award to be successful, the government would need to be open to engage in the process.

31. In my view, there would also need to be a collaborative approach to bargaining, whereby all parties try to solve the identified problems together, including by hearing and appreciating each other's perspectives. This is different to the conventional or traditional approach to bargaining, whereby employees bring a log of claims, and this is responded to by NSW Health with counter claims.

32. In the past, the Ministry for Health has not been willing to engage in a collaborative approach to bargaining and has been steadfast in negotiating about wages and nothing else. As a result of that approach, the current Award has fallen out of step with other Australian states and territories. In my view, there needs to be an appreciation of the value of a new award, which embraces the concept of "invest now and save later".

F. Clinician Involvement in Leadership and Decision-Making

33. It is of vital importance to involve on-the-ground clinicians in leadership and decision-making at the LHD-level due to their intimate knowledge of regional needs, challenges, and why particular strategies or programs will or will not work. At present, the bar for this kind of engagement is too low and, in my view, presents a clear barrier to the evolution of healthcare in NSW in the way that is needed.

34. In terms of the mechanisms for people with clinical experience to be more involved in decision making processes, I am interested by the proposal that the Chair of the Medical Staff Council for each facility within an LHD be appointed as an ex officio member of the LHD board.

35. One challenge I foresee with that proposal is that one of the key facets of the Medical Staff Council is that it provides a reporting line which is outside, or separate to, the executive reporting line. For example, if a member of a Medical Staff Council wishes to raise a concern in that forum, it can be escalated to the NSW Medical Staff Executive Council, and the advocacy in relation to that issue occurs outside the standard reporting line through line managers.

36. If the Medical Staff Council reporting structure were to be integrated into the LHD Board there would need to be some consideration given to the overlap of the reporting structures. Notwithstanding that, I understand that there are already some avenues currently available for Medical Staff Council representatives to participate in board meetings, which may provide some guidance on the appropriate approach.

Signature: 

Name: Dr Nicholas Spooner

Date: 20 / 9 / 24