Special Commission of Inquiry into Healthcare Funding

Statement of Serena Ayers

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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 as a witness. The statement is true to the best of my knowledge and belief.

2. This statement addresses the topics set out in the letter of 28 June 2024 issued to the Crown Solicitor's Office, relevant to my role.

A. INTRODUCTION

3. I am the Director of Medical Services (**DMS**) of the Inland Network at Southern NSW Local Health District (**SNSWLHD, the LHD**). I am also a former Senior Staff Specialist and Clinical Director in Emergency Medicine for NSW Health. A copy of my curriculum vitae is exhibited to this statement (**MOH.0010.0461.0001**).

4. In this role, I have three key areas of responsibility:

   a. Medical Workforce: I have oversight of workforce strategy and operations for the Inland Network, which includes recruitment and retention initiatives.

   b. Patient Safety, Quality and Risk Management: I am passionate about patient care and ensuring high quality service is being delivered, and work with frontline clinicians and the wider SNSWLHD Executive team on these matters.

   c. Administrative functions of the clinical service: this aspect of my role is similar to that of a Chief Medical Officer who has oversight and responsibility for administrative aspects of service delivery, such as managing the current intravenous fluid shortage with frontline clinicians and the wider SNSWLHD Executive team.

5. I have been in this role for approximately 6 months, since the end of January 2024. I report to the General Manager of the Inland Network, and through them to the Executive Director of Operations for the LHD.

6. The Inland Network comprises the area from the Southern Highlands down to the NSW/Victoria border and borders the Australian Capital Territory (**ACT**). I am responsible for the medical teams in the following 7 facilities:

   a. Bombala Multipurpose Service,

   b. Braidwood Multipurpose Service,

   c. Cooma Hospital and Health Service,

   d. Crookwell District Hospital,

   e. Goulburn Base Hospital

   f. Queanbeyan Hospital and Health Service, and

   g. Yass District Hospital.

7. There are currently three DMS positions across SNSWLHD – two Coastal Network DMSs, and myself (the Inland Network DMS). One of the Coastal DMSs is also the acting Executive DMS. We meet formally every week and all work closely with each other. From my observations, the medical workforce issues facing the Coastal Network are similar to those facing the Inland Network and rural healthcare more broadly across Australia. The key difference is that the Coastal Network has less key worker accommodation compared to the Inland Network.

B. WORKFORCE ISSUES AND THE SPECIALIST MEDICAL COLLEGES

8. There are many deeply committed clinicians in SNSWLHD who are truly passionate about rural healthcare. They are delivering the best frontline care and education that they can with limited resources. In my view, clinicians need to be enabled to leave the metropolitan setting by being offered the right incentives. I am encouraged by the current recruitment initiatives being run by the Ministry of Health (**MOH**), including the rural scholarships and Rural Health Workforce Incentives Scheme.

9. There is a perception amongst medical trainees that medical training in rural and regional areas is not as good as in metropolitan areas, which is also perpetuated by many metropolitan-based specialists. In my view, this is in part due to a longstanding bias of and messaging sent by specialist medical colleges around top-level practice and accreditation only being available in a metropolitan centre. I believe it is important to

challenge these assumptions. Whilst there is the greatest resourcing in metropolitan centres, this does not mean that there are not also skilled clinicians delivering high quality health care and education in rural settings.

10. The specialist colleges could do more to support and mandate rural training placements. Trainees may not be required to undertake a rural term at all, or only spend 3 to 6 months in a rural setting where it is mandated. The maximum amount of training time that a trainee can spend in a rural post is often decided through the specialist medical college's accreditation framework. Granting accreditation to rural training centres in a way that allows trainees to spend a greater proportion of their total training time in that rural setting, and mandating rural placements, would increase the chance that trainees will stay long term in a rural setting.

11. In my view, the impact of the above is that attracting, recruiting and retaining a medical workforce in rural areas is very challenging. Rural facilities then have little choice but to employ casual or a locum workforce to fill gaps, driving up the cost of rural healthcare delivery. Continuity of care to individual patients can also be affected if frontline patient care is not delivered by a regular local workforce, but by different short-term locums filling in service gaps, and who may change every few days.

12. The level of accreditation from the specialist colleges also impacts the ability of rural hospitals to recruit skilled overseas trained specialists with comparable training and practice to the Australian healthcare setting, as those specialist colleges may mandate that specialist candidates spend their period of peer review at a higher accredited metropolitan centre. Once recruited to a metropolitan centre, overseas specialists are less likely to venture to rural areas following their period of peer review. These frameworks of metropolitan-centric policies by many of the specialist medical colleges make it near impossible for rural health services to achieve equity.

C. THE JUNIOR MEDICAL OFFICER (JMO) WORKFORCE GAP AND ITS IMPACT ON MEDICAL WORKFORCE PIPELINE

13. Having a continuous JMO workforce pipeline is essential to creating future rural registrars and specialists. Each term there are approximately 25 JMOs from ACT, specifically 19 post graduate year (**PGY**) 1 and 2 JMO doctors, and the remainder are PGY 3+, in SNSWLHD. All PGY1 and 2 JMOs in SNSWLHD are currently seconded from ACT Health through a longstanding historical arrangement (**the ACT JMO arrangement**) and not connected to any HETI Prevocational Training Network. This

creates a break in the medical workforce pipeline (described below) and prevents NSW JMOs coming to SNSWLHD for their first 2 years following medical school graduation, as SNSWLHD is not listed as part of any NSW prevocational training network, making this region "invisible" to NSW based medical graduates.

14. Currently, SNSWLHD trains rural medical students from the Australian National University (**ANU**) during their student placements. There is no agreed rotation of students from any of the NSW medical schools, but SNSWLHD occasionally receives requests for placement from individual medical students studying at other medical schools. Some of the medical students placed in SNSWLHD from the ANU are originally from the SNSWLHD geographical region, or other rural areas, and may be part of the NSW Rural Resident Medical Officer Cadetship program. They are then unable to apply for a JMO position in SNSWLHD through NSW when they graduate from medical school, because SNSWLHD is not part of a HETI Prevocational Training Network as described above. The only pathway to a PGY1 or PGY2 JMO job at SNSWLHD is to apply through ACT Health, where they are not guaranteed a rural placement in SNSWLHD, but instead mandated to work in Canberra for at least part of their training.

15. This is of particular importance to local First Nations medical students from the local region who cannot apply to work as JMOs and train on Country unless they apply to ACT Health. However, rural placements cannot be guaranteed under ACT Health. NSW programs such as the Rural Cadetship Program, Rural Preferential Recruitment, and the Aboriginal Medical Workforce Pathway cannot be applied to SNSWLHD whilst the LHD sits outside of the NSW HETI framework. It is of vital importance that these structural misalignments are corrected to grow and develop First Nations medical workforce capability locally to deliver the objectives of the National Agreement on Closing the Gap.

16. I consider it a significant disadvantage that rural medical students cannot be converted into PGY1 or PGY2 JMOs unless they apply to ACT Health due to our lack of connection to HETI Prevocational Training Networks. Feedback from rural medical students is that they want JMO placements in a rural setting, and so have voiced that an application to a large metropolitan health service does not fit their needs. It is then much less likely that they will move to the area by the time they reach PGY3. Current SNSWLHD Medical Workforce Unit data suggests that SNSWLHD has trained approximately 340 JMOs in the past 5 years from the ACT, and only 3 have remained or returned after their original placements. Significant time, effort and cost has gone into training junior doctors from ACT Health by our senior medical workforce but has resulted in almost no return for NSW and the local rural workforce pipeline.

17. In my view, the ACT JMO arrangement in its current form is no longer fit for purpose, either strategically or operationally. ACT Health is focussed on training a metropolitan medical workforce based in Canberra. SNSWLHD's focus and strategies are around building a sustainable and skilled rural workforce, embedded and committed to our rural communities.

18. Currently, ACT Health determines the number of JMOs that are sent each term to SNSWLHD, largely without input from SNSWLHD. As a result of shortages of JMOs in Canberra and compounded by strategic misalignment of SNSWLHD placements with the goals of ACT trainees (who want to work and train in metropolitan centres), SNSWLHD is on the receiving end of a near continuous JMO shortfall from the ACT. SNSWLHD is therefore reliant on a locum workforce and considerable overtime at significant cost in order to maintain core, frontline services.

D. MEDICAL STUDENT TRAINING OPPORTUNITES

19. Our future medical workforce strategies should include the mentoring and preferential selection of local First Nations students wanting to pursue a career in health. Local First Nations medical student candidates should be preferentially selected for medical student placements in the LHD.

20. We are currently working on increasing the medical student presence within SNSWLHD. I envision the further development and expansion of SNSWLHD's training capability, initially established through a partnership with the ANU Rural Clinical School, to increase the number of local medical student placements. Increasing medical student numbers could also be achieved through partnerships with additional medical schools that are focussed on delivering future rural workforce strategies and placements. Locally trained medical students are much more likely to stay in the LHD for further training. This focus on the rural workforce pipeline, starting at the medical student stage, is in line with strategies and initiatives in other regional and rural areas across the country.

21. We have had conversations with the ANU as part of this strategy to increase the number of medical students placed in the Inland Network. As a result, the Inland Network is taking 10 final year medical students in the PRINT program, as "apprentice JMOs". They will be shadowing a medical team for 4 weeks under full supervision to give them experience of working within a 3-person rural medical team (commonly a JMO, registrar and a specialist). This provides a useful contrast to the larger medical teams in Canberra where

JMOs are likely to have a less hands-on clinical experience within a larger medical team setting.

E. MEDICAL WORKFORCE OPPORTUNITES

22. In my view, SNSWLHD should decrease its reliance on an ACT-only JMO workforce, and move towards having both NSW and ACT medical training networks, to produce a sustainable future pipeline. I envision SNSWLHD adopting the Albury Wodonga Health model, which has its own rurally grown medical workforce and connections with both NSW and Victorian training networks. Historically, there has been concern within the LHD that adopting a hybrid model such as the Albury Wodonga Health model might disrupt the operational relationships with the ACT as our nearest referral centre for tertiary facilities. In my view, the cross border working relationship and training JMOs from both NSW and ACT are not mutually exclusive.

23. We have had early discussions internally within the DMS group, clinician stakeholders across the LHD, the SNSWLHD Executive Director of Operations and Chief Executive regarding a proposal for a hybrid model of JMO recruitment and staffing as above. We have also had several meetings with representatives from the Regional Health Division of NSW Health, HETI representatives and the Rural Doctors Network around rural training initiatives. I have an upcoming meeting with the Executive Director of Medical Services at the Canberra Hospital to better understand their strategic direction, operational pressures, and views on the future of their medical workforce pipeline. I am hoping that these discussions will support the development of an updated ACT JMO arrangement and a stronger rural workforce pipeline.

24. Re-establishing NSW training positions with HETI prevocational training rotations will allow a broader cohort of medical graduates to apply for prevocational training in SNSWLHD, including those with a rural focus, and improve the SNSWLHD workforce pipeline, from PGY1 through to specialist level.

25. Our workforce strategies should preference the selection of locally trained medical students for JMO positions and in particular medical students from our local First Nations communities. JMO selection should preference trainees demonstrating a commitment to rural practice, both in primary care and hospital practice.

26. Preferential recruitment and selection of First Nations clinicians across the region also supports the sustainability and capability building of Aboriginal Community Controlled Health Organisations (**ACCHOs**).

F. SNSWLHD OPPORTUNITIES

27. SNSWLHD is in the early stages of exploring an updated ACT JMO arrangement with the ACT and rebuilding linkages with NSW HETI Prevocational Training Networks. This involves determining what is sustainable for both ACT and NSW – for example, agreeing on sustainable and realistic numbers of JMOs for rotation from Canberra, and opening the door to PGY1 and 2 JMO recruitment from NSW.

28. A key aspect to consider in these negotiations is that Canberra Hospital is the closest tertiary referral centre for SNSWLHD patients, and that SNSWLHD has no regional referral hospital (Level 5 facility) within its boundaries to deliver higher acuity, higher complexity care to our local communities.

29. Despite the LHD's proximity to Canberra, a vital part of the support and commitment that NSW Government could give SNSWLHD is to consider developing a Level 5 facility within this region that would support the delivery of cost-effective rural healthcare services closer to home for NSW rural residents living in our geographic region.

30. The development of a Level 5 facility within the LHD would also attract a skilled workforce to the region, as many young clinicians want to develop and experience higher acuity cases and more complex care. The ability to train in a variety of settings and offer a wider range of training experiences from community to a rural hospital network supported by a Level 5 facility, would be a very attractive proposition for local trainees and future rural GPs, rural generalists and rurally trained specialists. From anecdotal evidence, specialist and trainee feedback locally, many clinicians see only doing metropolitan hospital work as becoming increasingly unsustainable in the longer term.

G. BUILDING ON ABORIGINAL HEALTH SERVICES

31. Medical workforce opportunities described above link to future capacity to deliver Aboriginal healthcare initiatives.

32. Complementary to this, an Aboriginal Health Centre recently opened on the Goulburn Hospital campus. It was the subject of extensive co-design with the community, who had advocated for the need for more culturally safe healthcare spaces in our hospitals. I have received anecdotal and informal feedback from members of our local First Nations

communities who have expressed that they feel connected, comfortable and safe in that space.

33. The Aboriginal Health Centre presents an opportunity to co-design and build further culturally safe models of care that enable care closer to home and on Country, led and delivered by First Nations clinicians and others trained in culturally safe and trauma informed practice. Culturally safe, co-designed care delivers effective health and wellbeing, addressing the ongoing issues of colonisation and intergenerational trauma, and meeting the objectives of the National Agreement on Closing the Gap through initiatives that deliver measurable, sustainable outcomes.

Dr Serena Ayers

Witness: Lucy Blair

8 August 2024

Date:

8 August 2024

Date: