

# International Medical Graduate Clinical Readiness Program

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Pilot Evaluation Report

April 2024

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The NSW Ministry for Health acknowledges the traditional custodians of the lands across NSW. We acknowledge that we live and work on Aboriginal lands. We pay our respects to Elders past and present and to all Aboriginal people.

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# Executive Summary

The International Medical Graduate Clinical Readiness Program (ICRP) pilot was developed to provide International Medical Graduates (IMGs) who are struggling to gain employment with an opportunity to complete a voluntary clinical placement in a NSW public hospital. Participants worked as Medical Support Officers (MSOs) across multidisciplinary teams to help them learn about the Australian healthcare system, improve communication with patients and within multidisciplinary teams, and build effective relationships within the health system. International Medical Graduates (IMGs) were not registered by the Australian Health Practitioner Regulation Agency (Ahpra), were not charged to participate in the program and were indemnified to undertake basic clinical procedures.

The primary goals of the program were:

- to provide candidates with an introduction to the Australian health system and culture
- to teach candidates how to communicate with patients and within a multidisciplinary team, and
- to provide candidates with an opportunity to undertake some basic clinical tasks and procedures.

At the pilot’s end, the NSW Ministry of Health undertook an evaluation via a mixed-method, two-stage descriptive study using online surveys and semi-structured interviews with consenting participants. The participants included the MSOs, Directors of Training (DoTs), supervisors and members of the multidisciplinary team.

### Key findings:

Some of the identified benefits of the program included:

- LHDs agreed that the program was beneficial in supporting IMGs to enter the workforce. Of the 55 applicants who completed the program, 37 (67%) have been employed or were about to be employed in a medical role.
- MSOs found the placement to be very beneficial overall; 88% found the program very valuable, and 98% said they would recommend it to other international graduates.
- Participants appreciated having the opportunity to work in a team, to perform basic procedures under supervision and to learn about the NSW health system. They most enjoyed interactions with patients, including conducting histories and consults and performing basic exams.

## The ICRP Pilot Program timeline



Director of Training was funded to provide clinical and professional leadership, education and support to the MSOs at each site. A total of 56 IMGs began the program across eight LHDs (five of which were regional)

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- MSOs were able to work across a wide range of specialty areas, including general medicine, general surgery, emergency department, geriatrics and intensive care. This gave them a well-rounded view of the NSW health system.
  - The orientation was found to have improved MSO knowledge across many areas. There was overwhelming support for the centralised orientation, with 89% of respondents indicating that the orientation program was informative and prepared them for their placement.
  - The supervision arrangements provided sufficient support for MSOs – 87.8% of surveyed MSOs said they felt supported to discuss issues with their Director of Training and 92% said they felt supported to learn and raise issues with their supervisor.
  - Some MSOs reported that professional feedback was less regular and not formalised – only 47% reported that they received a completed Performance Development Plan.
  - Recency of practice had an impact on MSO preparedness. If it had been more than five years since they had last practised medicine, it impacted performance during clinical placement, which put additional pressure on multidisciplinary teams.
  - There was some variability in the overall program implementation, largely due to time constraints.
  - There was an unexpected larger financial impact on MSOs placed in regional and rural settings due to accommodation constraints, which caused additional pressure.

Some of the identified challenges and barriers included:

- Not all local orientation programs were sufficiently comprehensive, which meant that some MSOs struggled initially.
- The MSO scope of practice was not clear to all teams – due to the program's rapid implementation, some clinical staff did not receive the relevant information and therefore did not know what a MSO was.
- Some MSOs had difficulty understanding the Electronic Medical Record (eMR) system. Many had difficulties accurately documenting their ward rounds and lacked the necessary typing skills to keep up with documentation.

# Recommendations

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**Recommendation 1**

The ICRP should continue as a workforce strategy to support IMGs entering the NSW Health workforce.

**Recommendation 2**

Refinements should be made to the ICRP selection criteria and recruitment process to manage recency of practice concerns.

**Recommendation 3**

Ministry of Health (MoH) to further refine the structure and content of centralised and LHD orientation programs.

**Recommendation 4**

An optional extension of up to four weeks should be made available in addition to the 10-week placement period.

**Recommendation 5**

Minor changes must be made to ensure consistent clinical placement experience.

**Recommendation 6**

MoH should provide additional support to LHDs and Directors of Training.

**Recommendation 7**

Additional centralised education sessions should be developed.

**Recommendation 8**

The limited accommodation options in regional NSW should be addressed.

**Recommendation 9**

Allow greater flexibility of funding for the Directors of Training and LHD support for the program.

**Recommendation 10**

Provide additional education to MSOs about employment in NSW and Ahpra registration.

# Introduction/Background

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NSW Health is the largest health system in Australia, employing around 176,000 people across 228 public hospitals that span 15 local health districts (LHDs) and three specialty networks.<sup>1</sup>

NSW Health is also the largest employer of medical professionals in Australia, employing over 15,500 full-time-equivalent frontline medical staff. Of these, about 37% are employed in rural and regional areas.

Workforce modelling suggests that in the next three to five years, approximately 40% of the NSW medical workforce over the age of 60 will most likely retire and there will be a need for an additional 212 doctors per year to enter the workforce by 2040.<sup>2</sup> New doctors entering employment in NSW comprise those graduating from an Australian or New Zealand university and those that have completed a recognised medical degree in another country, also known as International Medical Graduates (IMGs). Supplementing the medical workforce with doctors trained in a country other than Australia or New Zealand is one of the solutions currently being used to address these shortages.

There are currently two main pathways to medical registration for IMGs: the competent authority and standard pathways. There are many IMGs from non-competent authority countries who find it difficult to gain employment in Australia. Barriers include difficulty gaining work experience in an Australian healthcare setting, not having practised for a few years and lack of familiarity with the Australian healthcare system.

Many IMGs directly approach NSW Health hospitals, GP practices and other healthcare providers to ask for observerships in an attempt to gain some experience in Australia. But observerships are restricted by the lack of indemnity for IMGs, so IMGs cannot use the hospital systems or directly interact with patients.

In response to the growing need to facilitate more doctors entering the health system, NSW Health developed a pilot program to reduce barriers to IMG employment. The IMG Clinical Readiness Program (ICRP) was established to provide participants with some basic clinical experience in a NSW public hospital, working within multidisciplinary teams to gain an understanding of communications and system processes, and to build relationships. The primary goal was to prepare the IMGs to become work ready and successfully apply for junior medical officer roles within the NSW Health public sector.

There are programs in Australia with similar goals. One program currently running as part of Victoria Health is the Monash IMG Preparation Program (MiPreP). It provides IMGs with a 12-week program (four weeks' classroom and eight weeks' clinical training) at a cost to participants. Monash Health assists candidates to gain provisional/limited registration prior to starting the program.

The ICRP is unique in that the participants are not registered by Ahpra and are not charged a fee to participate. However, it is different to a medical observership program in that the participants are indemnified to undertake basic clinical procedures such as taking a medical history, performing basic clinical examinations and basic procedures under supervision such as IV cannulation. The ICRP is a voluntary program; participants were unpaid and were additional members of the medical teams during their clinical placements.

<sup>1</sup> NSW Health (2023) [Snapshot: Annual report 2022/23, NSW Health, accessed 9 April 2024.](#)

<sup>2</sup> NSW Health (2023) [NSW Medical Workforce, NSW Health, accessed 9 April 2024.](#)

# Development of the IMG Clinical Readiness Program (ICRP)

## ICRP Pilot Structure

A working group, made up of representatives from the Ministry of Health, local health districts (LHDs) and the Health Education and Training Institute (HETI), was established to design and develop the pilot program. The group's members included Executive Directors of Medical Services, Junior Medical Officer Managers and Directors of Medical Education and Training.

The working group developed the ICRP as a structured 12-week program, consisting of three parts:

- Part 1 – five days of intensive orientation training at a centralised location. This included learning about the Australian healthcare system, communication techniques and simulated clinical learning.
- Part 2 – five days of local orientation, introducing site-specific information and intensive training in the use of the electronic medical record systems.
- Part 3 – ten weeks of supervised clinical practice on a ward/unit supported by a dedicated supervisor at post graduate year 3 and above and a site Director of Training. The placements were intended to provide a general experience and would ideally be based in medical, surgical and emergency departments.

LHDs were invited to participate in the pilot through an expression of interest (EOI). Eight LHDs submitted EOIs, and all sites were included in the pilot. Five of these were in rural and regional locations (see Appendix 1 for additional information on the recruitment and selection process). A maximum of eight IMGs were allocated per LHD.

## Expected Program Outcomes

The primary goals of the program were:

- to provide candidates with an introduction to the Australian health system and culture

- to help candidates improve their communication with patients and within multidisciplinary teams, and
- to give candidates an opportunity to undertake some basic clinical tasks and procedures.

At the end of the program, each candidate was to receive a Professional Development Plan (PDP), completed by their respective DoT and supervisors. Their PDP outlined their individual strengths and areas that required additional training or support. It was hoped that the participants could make connections with senior medical staff to act as referees and support for future employment opportunities.

## Scope of Practice and Indemnity

The IMGs accepted into the ICRP were called Medical Support Officers (MSOs). The MSOs were not registered medical practitioners but were indemnified by the NSW Treasury Managed Fund to work under direct supervision within a strict scope of practice.

MSOs are expected, under supervision, to have patient contact including:

- participation in ward rounds
- conducting clinical histories and basic clinical examinations
- reviewing and entering notes in the eMR, with a medical practitioner countersignature
- performing basic procedures under supervision. The procedures are venepuncture, IV cannulation and simple suturing.

If the MSO is considered competent in a task or procedure, they could undertake this task without direct supervision. This requires clear direction from the supervisor to the IMG with a strict scope to be communicated.



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### Not included in the Scope of Practice:

1. prescribing fluids/medications
2. ordering pathology or radiology tests
3. providing a clinical opinion to patients
4. providing any clinical updates/information to patients and families
5. intimate patient examinations
6. the completion of any legal documentation, such as a Certification of Death, medical certificates.

The MSOs were required to gain the patient's consent before undertaking any direct clinical tasks, such as conducting a clinical history or examination. To ensure patients were appropriately informed, they were given a fact sheet to help the medical teams and MSOs to explain their role. The fact sheet outlined the scope of the MSO's role and explained that patient involvement was voluntary and not consenting would not impact their care.

### Site Directors of Training

The Ministry of Health funded a Director of Training for each pilot site. The role was allocated 0.4 FTE per eight MSOs. The role was structured to:

- provide clinical and professional leadership, support, education and supervision to the MSOs
- design and monitor the local orientation and training programs for MSOs, and
- ensure that the MSOs received adequate supervision, and work with the supervisors to ensure they were given constructive professional feedback in the middle and at the end of the program.

## Orientation

### Central Orientation

The central orientation was hosted in the Sydney CBD from 10 to 14 July 2023 and aimed to provide a comprehensive overview of NSW Health governance, culture and communication, as well as providing simulated learning opportunities. Orientation training was delivered by a broad range of multidisciplinary educators including directors of prevocational training, specialist medical officers, junior medical doctors, former IMGs now working in NSW, and a specialist linguist to assist with medical slang, pronunciation and accents.

The sessions were a 50/50 mix of lecture style and smaller-group, workshop-style activities.

Participants were given one full day of simulation training at a simulation centre. This covered a broad range of procedural skills workshops including IV cannulation, venepuncture, interpretation of VBG/ABG blood gas, recognising a deteriorating patient and communicating within teams, with patients and between multidisciplinary teams.

### Site Orientation

During week two, the LHDs provided a site-specific orientation. The project team provided an outline of recommended learnings which included training in local systems such as electronic medical records (eMR) and other systems critical to daily ward tasks and processes. The MSOs were given additional training in basic clinical skills such as IV cannulation and access to My Health Learning, the NSW Health eLearning platform. They were required to complete a suite of e-learning modules before their placements implementation.

# Participant Demographics

The application process did not collect information related to gender or age and during the recruitment process, the selection panel did not know the applicants' genders. These statistics were collected after the candidates were selected and was required as part of the pre-employment checks.

The candidates' ages ranged from 25 to 48 years old, with the average age being 35 years. Only nine candidates were male, and the remaining 47 were female (84%).

## Country and Language of Medical Degree

An analysis of the MSO cohort found that a significant majority were trained in Pakistan, followed by Bangladesh.

Of the MSOs that responded to the End of Program survey (49), 41% had completed their medical degree within the previous 10 years

and 59% had completed their degree more than 10 years ago.

Most respondents (92%) had completed their medical degree in English.

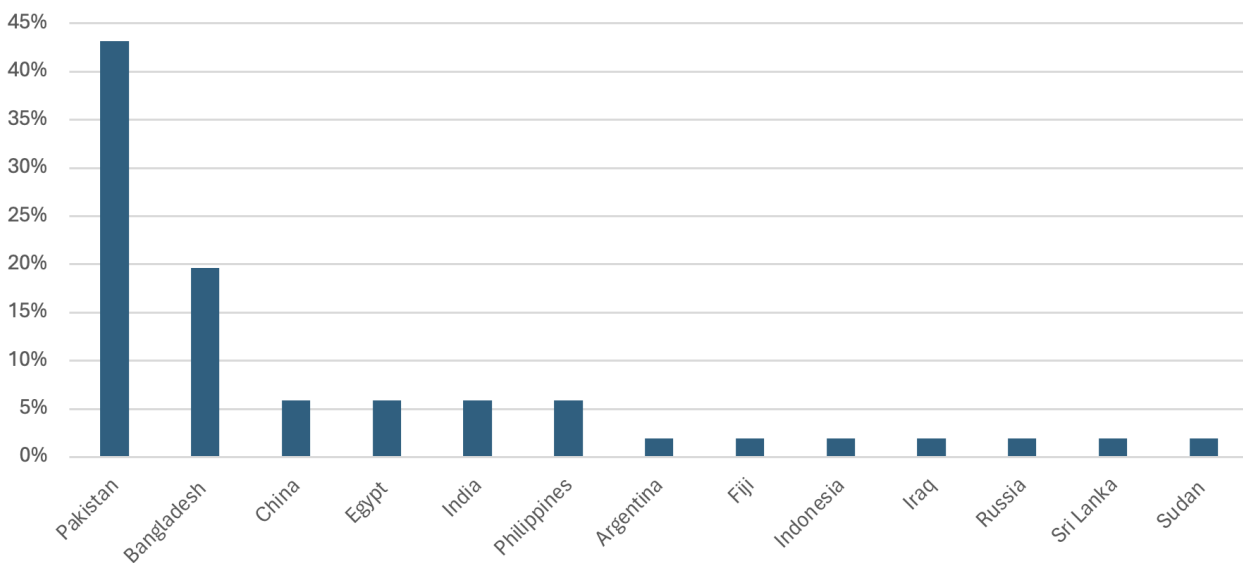
## Completion of AMC Part 2 Exam

Completion of the Australian Medical Council (AMC) Part 2 exam was not part of the pilot's selection criteria. The post-program survey found 49% of respondents had sat the AMC Part 2 examination and, of those, 40% had passed.

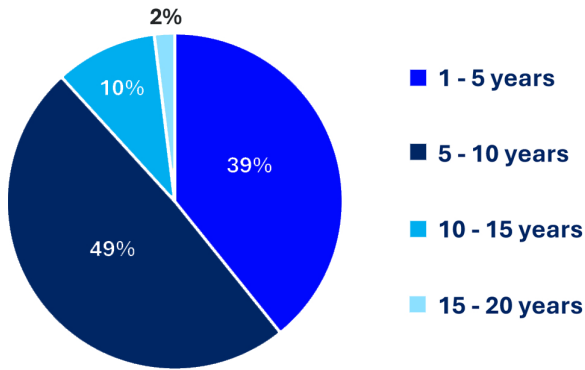
## Time Living in Australia

Most of the MSOs (88%) had lived in Australia between one to 10 years, and the biggest proportion had lived in Australia for five to 10 years.

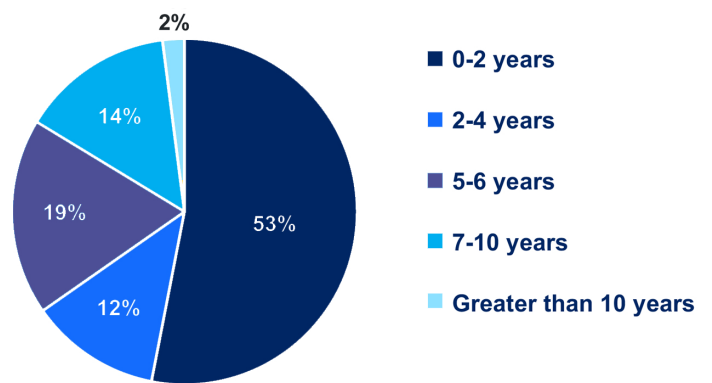
MSOs by Country of Medical School



Length of time living in Australia



Length of time since last employed as a doctor



### Recent Medical Experience

The selection criteria did not include a specific requirement to have practised medicine recently. More than half (53%) of the MSOs had practised as a doctor within the past two years (2022–2023). A large proportion (83.7%) of the MSOs had worked as a doctor within the past six years. Many IMGs maintained recency of practice by returning to their home countries to work.

# Evaluation of the ICRP Pilot

## Evaluation Framework

The NSW Ministry of Health has conducted an evaluation of the ICRP Pilot to determine the following:

- How well did the ICRP program perform?
- Did the ICRP program achieve its intended outcomes, namely:
  - To what extent has the ICRP program prepared IMGs for working within NSW Health?
  - What were the factors that led to MSOs securing medical positions?
- What challenges and barriers were experienced during the ICRP pilot?

## Evaluation Methodology

Evaluation of the ICRP pilot is essential to understanding the program's value. This evaluation will investigate the program's successes and areas for improvement, and will set out recommendations for how the program could be improved in future iterations. The evaluation was conducted in-house via a mixed-method, two-stage descriptive study approach, including online surveys and semi-structured interviews with consenting participants. These included the MSOs, Directors of Training (DoTs), supervisors and members of the multidisciplinary team.

## Surveys

### Centralised Orientation Survey

During their centralised orientation, MSOs were given a brief survey to complete at the end of each day. They were asked to evaluate each session and to compare their knowledge before and after completing the training. Response rates were close to 100% for all five days.

### MSO End of Program Survey

MSOs that completed the program were given an end of program survey in week 12, though 19 MSOs had an opportunity to extend their clinical placement period by four weeks to a total of 16 weeks. A total of 49 MSOs responded to this survey, representing a response rate of 89%.

## Multidisciplinary Team Survey

The members of the multidisciplinary team, the nursing, allied health, medical staff and MSO supervisors, were also given a follow-up survey. However, there were significant barriers to collecting information from this group. The project team did not have direct access to multidisciplinary team members' contact details and therefore could not distribute the survey to many people. For this reason, the sample size for the multidisciplinary team survey is very small (n=15), but, although not statistically significant, the information captured from this limited cohort did inform program components that could be improved for future rounds.

Of the total respondents, 11 were direct supervisors of the MSOs, representing 73% of the final response rate to this survey.

## Post-Program Follow-Up Survey

The MSOs were given a follow-up survey in January 2024 to evaluate their efforts to secure employment both before and after completing the program. The survey was open for seven days and a total of 51 MSOs responded, representing a response rate of 93%.

## Interviews

The project team developed two sets of interview questions; one for the MSOs and the other for the DoTs.

The MSO interviews were conducted one-on-one, providing an opportunity to capture more detailed information about their experiences. MSOs were invited by email to volunteer to be interviewed. At least one MSO per LHD was interviewed, with a total of 13 MSO interviews. All site DoTs were interviewed. All interviews were conducted via Microsoft Teams, and responses were anonymised and collated to enable thematic analysis (which later formed the basis of the evaluation report findings).

# Evaluation Findings

## How did the ICRP program perform?

### Centralised Orientation Learning Outcomes

MSOs were asked to assess their knowledge and understanding of the NSW health system, of working in multidisciplinary teams, communication in clinical settings and the daily duties of a junior medical officer (JMO).

“It helped me in establishing my understanding of the NSW health system.”

MSO responses prior to commencing centralised orientation indicated they had a fair to limited knowledge of the NSW health system, multidisciplinary teams and clinical communication styles. MSOs rated their understanding of JMO duties as fair to reasonable, indicating a slight increase of confidence in this area.

At the completion of centralised orientation, the survey findings show that MSO knowledge was greatly improved across all these areas. Interestingly, 70% of MSOs rated their knowledge of expected JMO duties in NSW Health hospitals as greatly improved, indicating that perhaps their understanding of these duties prior to the orientation may have been overestimated. There was overwhelming support for the centralised orientation, with 89% of respondents indicating that the orientation program was informative and prepared them for their LHD placement.

### Orientation at Local Health Districts (LHDs)

LHDs were given a factsheet outlining the recommended topics and training for site-specific orientation, including a suite of recommended e-learning modules for the MSOs to complete before starting on a ward. The site-specific orientation experience was captured through interviews conducted with both the MSOs and DoTs. These showed there were variations in the orientation programs across the LHDs, with some MSOs receiving the full five days of recommended orientation on site and others only three days. A small number did not receive any site-specific orientation and were required to start immediately on the ward.

LHDs that were able to commit to a full five days of site-specific orientation found it was beneficial for both the LHDs and the MSOs, with MSOs feeling more confident about starting their clinical placements.

MSOs that did not receive a comprehensive site-specific orientation reported that they struggled on the ward and felt like a burden to junior doctors because they were required to ask more questions, didn't have access to local systems and took longer to complete basic tasks.

The most beneficial training during site-specific orientation was reported to be a tour of the hospital, reinforcement of some basic clinical skills training such as IV cannulation and basic life support as well as giving an overview of what to expect during the clinical rotation.

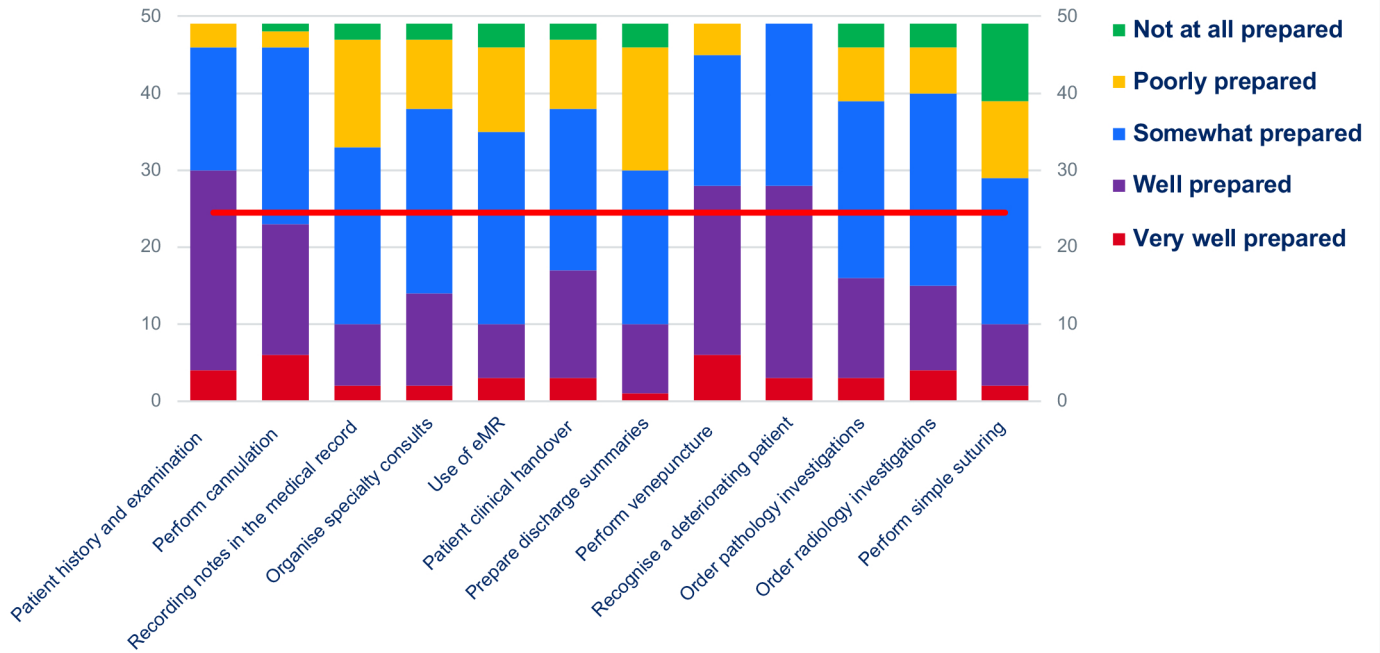
### MSO Preparedness Prior to Placement

The goal for the orientation was for the MSOs to feel prepared to start the clinical placements. The End of Program survey asked MSOs to rate their readiness to perform a variety of tasks and procedures following both the centralised and LHD orientations. Figure 1 below shows the MSOs' assessment of their readiness to perform the required tasks and procedures following orientation – the through line indicates the median response (see Figure 1 next page).

The skills that MSOs felt well to very well prepared to perform included conducting a patient history and examination, performing cannulation and venepuncture, and recognising a deteriorating patient.

The skills the MSOs felt somewhat poorly prepared to perform included ordering pathology and radiology investigations (with supervisor co-sign), preparing discharge summaries, clinical handover of a patient, use of eMR, organising consults and making accurate medical notes. To improve the MSOs' readiness for the clinical placements, future programs will need to provide more focus on the other aspects of orientation, particularly the use of eMR and medical documentation.

Figure 1: MSOs' assessment of their readiness to perform defined skills after orientation



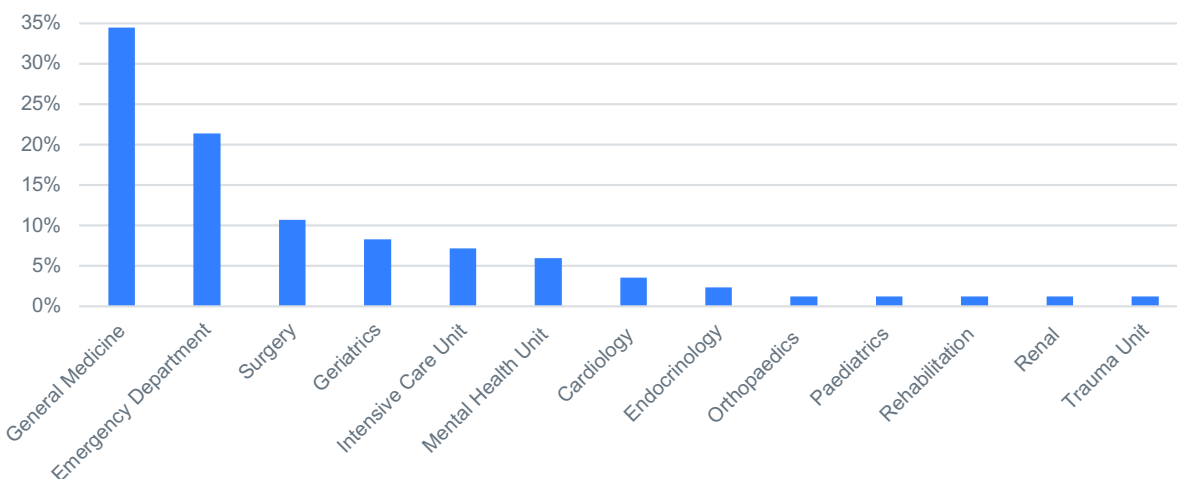
### Clinical Placement

MSOs reported they were rostered for 40 hours per week, Monday to Friday. They were not rostered for overtime or weekend shifts but there were some occasions when an MSO chose to stay on the ward past their finishing time if there was an interesting case or procedure to witness and complete. MSOs noted that the rostering pattern was flexible and allowed them to integrate well into the multidisciplinary team environment.

### Workload

The MSOs described their workload as generally light to moderate and very manageable. MSOs had the opportunity to learn and practise a variety of tasks and procedures. Some workloads were dependent on the clinical setting. For example, geriatrics was reported to be slower paced and less pressured than higher-volume areas like Emergency Departments (ED). The MSOs reported a preference for ED rotations to gain more experience; however, it was reported that ED

Figure 2: Specialties allocated to MSOs



## Evaluation Findings (Continued)

rotations required more hands-on support from supervisors and the multidisciplinary team.

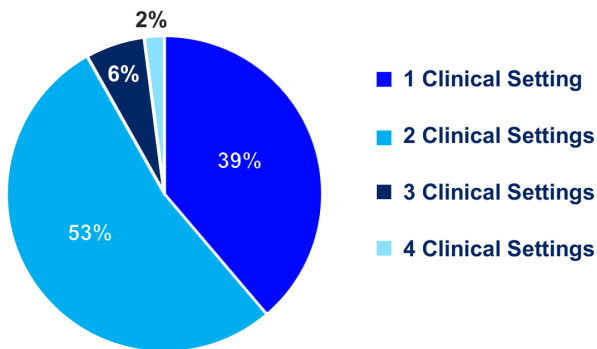
### Specialty Areas Worked

The program provided flexibility to LHDs to allocate either one ward rotation for 10 weeks or two different rotations (five weeks each) per placement.

Figure 2 (see previous page) indicates that the majority of MSOs (34.5%) worked in general medicine, followed by 21.4% in emergency medicine and 10.7% in general surgery.

Figure 3 below shows that 61% of MSOs were allocated two or more rotations during their placement, with 8% of MSOs experiencing three or four different settings.

Figure 3: Number of clinical settings experienced by the MSOs



The data suggests that two clinical placements is the preferred model for most sites; having three or more settings in a 10-week placement is not advised.

The MSOs reported preferring placements in ED due opportunity to experience a variety of clinical tasks. The fast-paced nature also suited many of the MSOs. The DoTs did not report the need for an ED placement for the program to be successful.

### Clinical Placement Duration

The program was designed to provide a 10-week clinical placement. Based on feedback from LHDs

during the program, an option was provided to extend some candidates for an additional four weeks for further development. A total of 19 candidates were offered and accepted this opportunity from the local health district.

DoTs had no specific concerns with the length of the placements. A 10-week clinical placement gave participants enough time to gain the necessary exposure without putting excess pressure on them to commit to further time without an income. The extension of some MSOs for up to 14 weeks was a suitable option for those who needed the additional support and were able to commit to the additional unpaid placement. However, candidate extension should be decided in consultation with DoTs.

### Scope of Practice

The MSOs reported that clinical staff on the ward often did not know what the role of an MSO was and had not received any information on the program. On many occasions, MSOs were required to explain their role and their scope of practice to nurses, allied health professionals and doctors on the ward. This proved to be quite onerous on the MSOs, and some MSOs reported feeling disconnected from the clinical team in those instances.

Although MSOs needed extra time to integrate into the multidisciplinary team environment, there were no reported issues with MSOs adhering to their scope of practice, and no reported issues or incidents regarding patient care or supervision. The MSOs felt that, with further iterations of the program, their scope of practice and roles would become clearer to the clinical staff.

### Skills Undertaken During the Clinical Placement

Overall, the MSOs were exposed to the critical elements of the program including conducting patient histories and examinations, attending and documenting ward rounds, preparing discharge summaries and completing medical record documentation, organising consults, and performing



## Evaluation Findings (Continued)

venepuncture and cannulation. Figure 4 shows the skills completed as reported by the MSOs.

All MSOs had access to the eMR system, Powerchart or FirstNet. DoTs reported that some MSOs had difficulty understanding the eMR system and many MSOs experienced difficulties with accurately documenting ward rounds and lacked the typing skills to keep up with documentation. This occasionally led to miscommunication within the team. DoTs consistently advised that candidates should consider additional training in their written and typing skills. However, DoTs reported that MSOs were able to learn quickly and improved their documentation skills over the course of the placement period.

The skills completed by the MSOs varied across the program. Exposure to areas such as patient admissions and assessing a patient to order pathology and radiology tests (with co-signing in eMR required by the supervisor) was inconsistent. This is likely due to the supervisor assessing the MSO’s competence to complete tasks. Consistent feedback from the MSOs showed that eMR access was inconsistent across LHDs, including the ability to see pathology and radiology results. This impacted the MSOs’ abilities to perform daily tasks and impacted the patient workflow. Suturing was attempted by a very small proportion of MSOs; however, it is not considered an essential clinical procedure for the program.

Future programs should ensure consistency of eMR access and expectations of skill exposure and completion for all MSOs in the program.

### Professional Feedback and Professional Development Plans (PDPs)

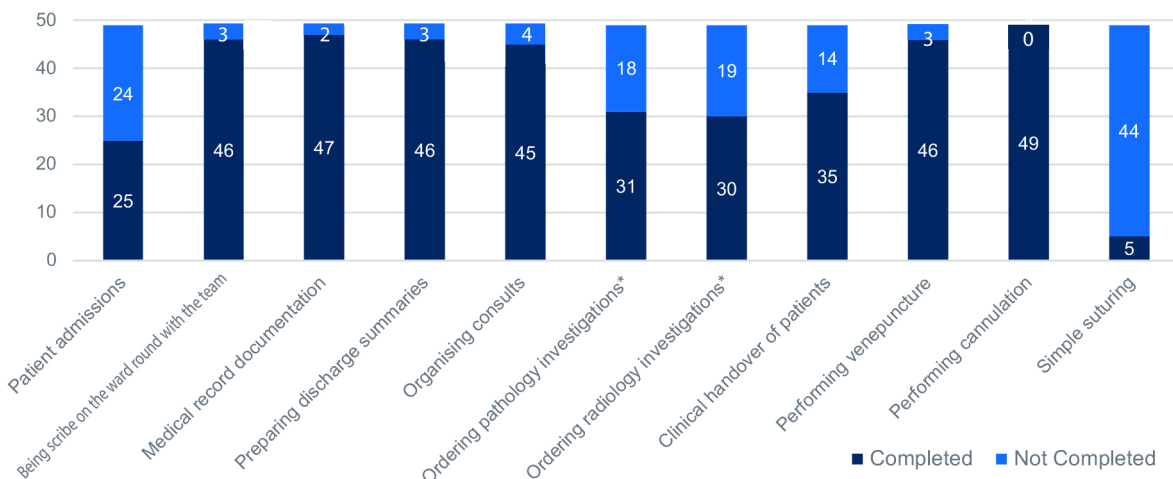
The mechanisms used for feedback varied across the LHDs, with some MSOs reporting weekly one-on-one meetings with their supervisor and DoT as an opportunity to reflect on the previous week’s activities and experiences and to receive formal feedback through reflections documented in a work plan. Some MSOs reported that professional feedback was less regular and not formalised.

The program required that all MSOs be provided with a Professional Development Plan (PDP) on completion. However, at the end of the program, only 47% of MSOs reported receiving a completed PDP. Some barriers identified included a lack of time, supervisors being too busy, or the MSO or supervisor being unaware of the requirement to complete the PDP.

### Role of the Director of Training

DoTs noted that they required an estimated one to two days per week on average to support the MSOs. This support included administrative tasks, meeting with MSOs, communicating with supervisors, managing clinical placements, ward rounds and arranging additional education and training sessions.

Figure 4: Completion of skills and procedures (as reported by MSOs)



\*Note that MSOs were not allowed to order pathology or radiology investigations – the graph denotes MSOs who were able to assess when patients needed tests and consult with a supervisor who would then order the test.



Some DoTs had additional staff available to help with the administrative aspects of the placement period and this proved beneficial.

Some DoTs provided additional education and training opportunities at their LHDs for the MSOs. Most commonly, MSOs were invited to attend the JMO training days and the weekly clinical case presentations, CV writing and interview preparations. DoTs had multiple ways of connecting regularly with MSOs such as regular face-to-face meetings, WhatsApp and email messaging, and interview practice sessions. Some DoTs visited MSOs regularly on the wards to check in. MSOs noted that they would usually go to their supervisor or a DoT for advice, issues management and escalation. Of the MSOs surveyed, 87.8% said they felt supported to discuss issues with their DoT.

### Supervision of MSOs

The program required a designated supervisor at a level of PGY3 or above to be responsible for the MSOs. Both the DoTs and MSOs were interviewed about the supervision on the ward. In general, it was reported that the day-to-day supervision of the MSOs was usually provided by the consultant, head of department or registrar. While on the ward, MSOs worked closely with interns and JMOs to complete tasks and procedures. It seems they relied on the junior doctor workforce for support and felt comfortable asking them questions. Most MSOs – 92% – said they felt supported to learn and raise issues with their supervisor.

**“My supervisor taught almost everything that he would teach his Intern/Resident. This gave me more confidence in working as a JMO if an opportunity is given in future.”**

The MSOs did report some variety among supervisors across clinical settings. For example, in EDs, there was greater rotations of the senior medical staff in charge of supervision. The surveys and interviews found that the MSOs that had a designated supervisor for the duration of the clinical rotation felt better supported to raise issues and felt better supported by the multidisciplinary team. MSOs that were not sure who their designated supervisor was or where the

supervisors were rotating Visiting Medical Officers (VMOs) or Locum Medical Officers, they felt less supported and unsure of who to raise issues with. This directly impacted on their overall experience.

### MSO Experience During Placement

**85%** of MSOs said they felt well supported by the medical staff

**77%** of MSOs said they felt well supported by the nursing staff

MSOs reported that the most positive aspects of the placement included the opportunities to work in a team, perform basic procedures under supervision and learn about the NSW health system. They most enjoyed interactions with patients, including conducting histories, consults and basic exams.

Feedback from the multidisciplinary team described MSOs as keen and engaged. Team members reported that the addition of MSOs created an environment where team members could interact closely and learn from each other. MSOs enjoyed the opportunity to learn to communicate and work effectively in a multidisciplinary team, including presentation of cases and collectively working through investigations.

### Centralised Education Sessions

The Ministry of Health arranged additional education webinars to assist MSOs to further develop their skills across the following topics:

- Communication skills
- Wellbeing for Junior Medical Officers
- Job application skills
- Interview skills.

Attendance rates were quite high, with over 90% attendance rate for all sessions. The Ministry team also arranged one-on-one sessions with a linguist to practise medical slang, language fluency and pronunciation. A total of 18 MSOs attended the 15-minute sessions and were required to do some basic preparation before the session. After the session, the linguist provided MSOs with work sheets and further activities to enable additional language and pronunciation practise.

# Did the ICRP Program Achieve its Intended Outcomes?

Overall, 88% of MSOs found the ICRP very valuable for their career. However, 98% of MSOs reported they would recommend the program to other IMGs.

Broadly speaking, the feedback received from MSOs, DoTs and other LHD staff indicates that the program was very beneficial and filled a key employment gap for IMGs in NSW. The MSOs reported that they had been living in Australia for years with no success in securing medical positions. Of those interviewed, 29% said they had applied for 50 to 100 Medical Officer jobs and 90% had attended zero to five interviews before applying for the ICRP.

## To What Extent Has the ICRP program Impacted on IMG Readiness to Work in NSW Health?

100%	of MSOs said their placement experience has increased their confidence in communicating with patients
90%	of MSOs said their placement experience has increased their confidence in undertaking patient clinical handover
96%	of MSOs said their placement experience has improved their ability to complete discharge summaries
100%	of MSOs said their placement experience has improved their history and examination skills

Evaluation data on work readiness is subjective. MSOs noted that they felt somewhat well-prepared to take on the MSO role, and the majority of respondents felt confident in their role within two to three weeks of their clinical placement. However, others took longer to adjust (this cohort was given an additional month to improve their job readiness). MSOs who had a greater gap in practice required a greater amount of support, either through an extension of their placement period or through additional mentorship by their supervisor or DoT.

DoTs reported that the MSOs’ capabilities at the start of the program varied. On average, they said it would take about three to four weeks for an MSO to perform their duties competently and about five to six weeks for the DoTs to assess the MSO’s level of competence to be engaged in the workforce.

“The IMG workforce is untapped – exposing them in well planned manner will give them a platform to perform and get noticed/get their start.”

No issues were reported by the supervisors or any other member of the multidisciplinary team working with MSOs, indicating that the MSOs’ role within the clinical team was well managed.

The DoTs were asked about the MSOs’ work readiness and what held them back from being at the level of an intern on day one. Some MSOs (35%) had not practised medicine for more than five years, and as a result there were issues with their patient communication style and baseline clinical knowledge.

Overall, the DoTs reported that MSOs were keen to work and were generally receptive to feedback, which contributed positively to their time at the LHD.

Although not all MSOs were at the level of a ‘day-one intern’ at the end of the program. The majority (93.9%) of MSOs agreed that their experience has helped prepare them to work as a doctor in NSW.

## Employment Outcomes

- At the start of the program there were 56 applicants, with 55 completing the full program.
- As of January 2024, 37 MSOs (67%) have commenced in a medical role. The types of roles offered include intern, Resident Medical Officer (RMO) and Senior Resident Medical Officer (SRMO), with RMO roles being the most common.
- Of the MSOs who completed the program, 31 were offered work in NSW, three are employed in Queensland, and one each employed in Victoria, Western Australia and the ACT respectively.

Of the MSOs who are about to start a medical role, the DoTs reported issues with obtaining registration. In some cases, it took 12 to 16 weeks from the date of their application to APhra. The reasons for the length of time to registration are mixed, usually due to completeness of information provided to APhra.

### Factors Contributing to Employment Outcome

Analysis has identified the following factors are likely to have contributed to successful employment:

1. Sitting the Australian Medical Council (AMC) Part 2 examination, and
2. Recency of Practice.

There were no other factors identified that predicted successful employment into the medical roles.

This analysis correlated with the feedback from the DoTs, who advised that those that had practised medicine within the previous five years and had attempted the AMC Part 2 exam seem to take less time to become competent in performing tasks on the ward. The preparation required to sit the AMC Part 2 exam improved the MSOs' knowledge and skills.

### Sitting AMC Part 2 Examination

Of the 49% of the participants who had previously sat the AMC Part 2 examination, 40% passed. Of those who sat the AMC Part 2 examination, 84% secured employment, irrespective of their exam results. Within this group, 100% of those who passed the AMC examination secured employment and of those who failed the exam, 73% secured employment.

Of those who did not sit the AMC Part 2 exam, 61% still secured employment.

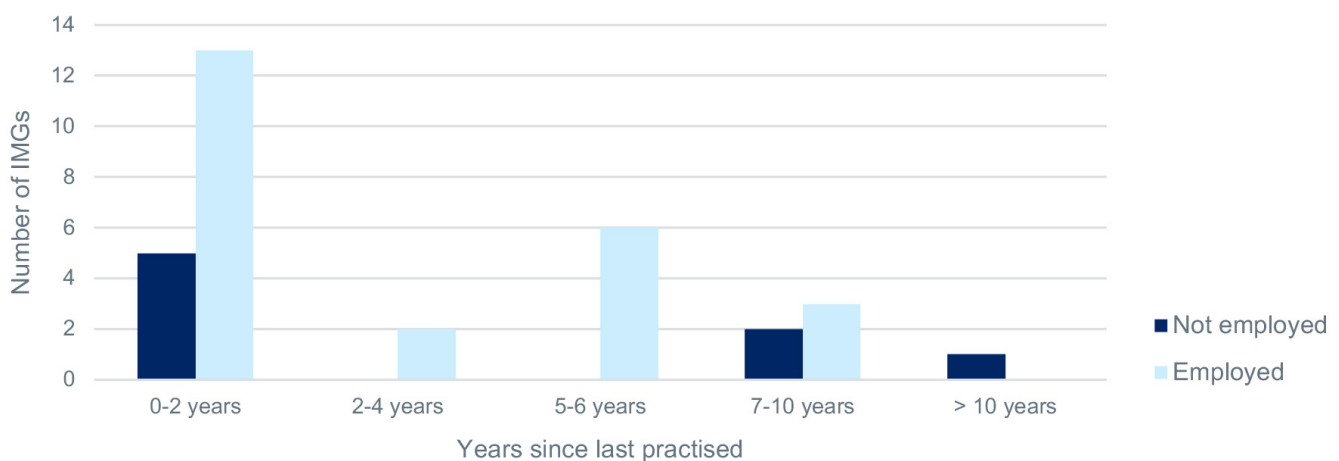
### Recency of Practice

Due to limitations in the data collection, a correlation between recent medical practice and employment cannot be analysed for the full cohort. For the 32 participants where the analysis could be made, the following findings showed that practising within the past six years resulted in a higher likelihood of success. In relation to other participants, 70% are employed, however their recency of practice is unknown, noting that those without practice within the previous 3 years required additional support.

It was clear from the DoT feedback that not having recent medical experience within the previous 3 years impacted on MSOs' performance during their placements. Even MSOs who had recently travelled to their home country to gain experience still struggled during the first half of their placement. This placed additional pressure on supervisors and the multidisciplinary team, as it was initially very time consuming to provide support and reassurance to this cohort.

Some of the MSOs who required additional support were able to extend their placement by a month to further develop their skills and experience. DoTs noted that even though additional support was required for this cohort, with time, they were able to reach the appropriate level of competency.

Figure 5: MSO employment outcomes by recency of practice



# What Challenges and Barriers Were Experienced During the ICRP Pilot?

## NSW Health Recruitment and Onboarding (ROB) system

The project team were not able to use the NSW Health Recruitment and Onboarding (ROB) system for any stage in the recruitment process due to limitations in its functionality. They were not able to use the ROB to advertise the ICRP, so the project team engaged the services of the NSW Health communications team, who assisted in messaging through the LinkedIn platform and reached out to multicultural communities to repost the LinkedIn advertisement. In the interviews, MSOs said they found out about the program through their peers and through IMG Facebook groups.

The recruitment, selection and onboarding of IMGs into the program proved challenging. ROB limitations also affected other stages of the pre-employment process that would ordinarily be automated. Without access to ROB automated systems, all pre-employment checks required a manual process and therefore additional time and resources to complete.

## LHD Readiness

The LHDs' readiness to receive the MSOs varied. This impacted on the MSOs' initial orientation and supervision, so there was less time available to make the most of the program. Some of this disparity was due to the program's time constraints and delays in the MSO recruitment process.

The majority of participating LHDs confirmed that they would participate in the ICRP in the future. It was described as an important and unique program that supported IMGs to get into the workforce and helped boost the NSW medical workforce. Only one LHD said they would not participate in the program again, due to internal governance issues as well as the teams being primarily staffed by VMOs, which affected their ability to appropriately support the MSOs.

## Integration of the MSOs into the Teams

Most teams were reported to be helpful and welcoming, however some MSOs said they felt

“Having had a gap in clinical practice, the role of MSO was extremely helpful in allowing us to refresh our clinical knowledge and skills.”

isolated. For example, some team members were not receptive to including MSOs in multidisciplinary team meetings. Only 63% of MSOs said they felt like a valued member of the team.

Some multidisciplinary team members noted the difficulties of not having time to prepare for the MSO placement. They reported that the pilot created additional work due to the extra supervision requirements, larger team rounds for patients, and less opportunity to give equal attention to students, interns and other JMOs.

There were some difficulties integrating the MSOs into teams in busier environments like emergency. However, these issues were resolved as time went on, and would be less likely to reoccur were the program to run again in future.

## System Understanding of MSO Role

Feedback from both the MSOs and multidisciplinary team members indicated that the role description and key responsibilities of an MSO were not well understood across LHDs. As the ICRP was a pilot, there was no foundational understanding of what an MSO was or what their scope of practice should be. The Ministry of Health distributed fact sheets to LHDs about the MSO role. MSOs themselves were informed of the role scope during orientation, and were required to communicate their scope of practice to all the teams they worked in.

MSOs reported that they had to continually communicate to teams about their scope of practice and role limitations (for example, not being allowed to communicate to relatives). Communication issues were compounded in wards where staff changed over frequently (such as VMOs and locums). MSOs were then required to repeatedly reintroduce themselves

and explain their purpose and role limitations every few weeks. However, these issues improved over time as the teams adjusted to the MSO capabilities, which in turn helped the MSOs to gain trust and build productive working relationships within the team.

### **Review of MSO Scope of Practice Within the LHDs**

Many MSOs noted a variability in the types of tasks or procedures they were able to do. Consideration should be given to whether an expansion or greater flexibility in the scope of practice would be beneficial. However, this should be done in consultation with multidisciplinary teams and supervisors where appropriate. Example inclusions could be more patient interaction (with supervision) or authority given to MSOs to order investigations in the eMR and allow access to radiology reports with a medical officer counter signature (this was a consistent issue for many MSOs).

### **Recruitment Pathways for MSOs**

There was clear feedback from both MSOs and multidisciplinary team members to include more opportunity for pathways to employment at the end of the placement. All LHDs are required to follow the standard recruitment and selection process in accordance with the relevant NSW Health Policy Directives.

Some suggestions would be to include job interviews at the end of the placement where there are vacant medical positions, or meeting with DoTs/supervisors to explore upcoming employment opportunities with their LHD or elsewhere. The multidisciplinary teams suggested that the placement could be supported by a locally informed recruitment strategy to assist with a pipeline to employment at the end of the program. Information webinars proved a useful support to MSOs in preparing job applications and interview skills. The ICRP project team could provide these sessions earlier on in the placement period and allow time for the MSOs to refine their knowledge and skills in this area.

### **Ahpra Registration**

A significant amount of feedback from MSOs and DoTs was around the participants in the program being unregistered. The MSOs felt that Ahpra registration would allow for a larger scope of practice and increase their work readiness. They also believed registration would allow for faster employment at the end of the program.

Participation in the ICRP does not contribute to recency of practice required by Ahpra. Changing the program to having IMGs registered will require the IMGs to pay the full cost of Ahpra registration, with no guarantees of ongoing employment. Having IMGs registered would also create significant delays and cost and would not resolve the issues around the Ahpra recency of practice requirements.

### **Impact on MSOs**

Many MSOs had to take leave without pay from their current employment or had to resign from their jobs to be able to participate in the program, and some had to leave young families behind to relocate. DoTs were concerned about the social and financial impact for these candidates. Some MSOs struggled with being away from their families and children for a long period.

Those who moved to regional areas had a significant accommodation cost to absorb. Short-term rental options in regional towns proved limited and expensive, adding an additional financial burden to the MSOs in these locations. This issue was unexpected and therefore created difficulties in helping MSOs secure appropriate accommodation in regional locations across the pilot sites.

### **Conclusion**

The evaluation resulted in ten recommendations aimed at streamlining the ICRP. These recommendations seek to address existing barriers and ensure a more consistent experience for MSOs across LHDs in future iterations.



# Recommendations

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## **Recommendation 1: The ICRP should continue as a workforce strategy to support IMGs entering the NSW Health workforce.**

- 1.1 NSW Health will refine the ICRP design in line with the evaluation report recommendations and continue the program for 2024 and onwards.

## **Recommendation 2: Refinements should be made to the ICRP selection criteria and recruitment process.**

- 2.1 Include additional weighting to AMC Part 2 examination during the selection process (to be added as a desirable criteria).
- 2.2 Include a new selection criteria: that applicants must have worked as a medical doctor within the past three years.
- 2.3 MoH should work internally to scope options for more efficient MSO recruitment via the ROB system for future programs.

## **Recommendation 3: Review the structure and content of centralised and LHD orientation programs.**

- 3.1 Form a working party to review the central orientation program and consider the following:
  - inclusion of more small-group activities
  - increased time for procedural skills training (to ensure all participants can undergo this training)
  - increased focus on areas where MSOs did not feel well prepared.
- 3.2 Put together a working group to further develop a structure for LHD orientation programs to ensure a consistent experience.
- 3.3 Consider including local orientation activities which give MSOs the opportunity to practise typing skills in a clinical context.

## **Recommendation 4: Include an optional extension period to the current clinical placement.**

- 4.1 Retain the clinical placement at 10 weeks, with an optional four-week extension where deemed necessary and by mutual agreement with the LHD and the MSO.

## **Recommendation 5: Minor changes to be made to ensure consistent clinical placement experience.**

- 5.1 Future ICRP rounds should have a maximum of two clinical rotations across 10 weeks (with one rotation in a general area such as a medical, surgical or emergency placement).
- 5.2 A consistent scope of practice is required for MSOs across all sites (particularly relating to eMR access).
- 5.3 MoH to connect with LHD contacts to ensure PDP requirements are understood and implemented.
- 5.4 MoH to provide a log book for MSOs to meet the program's core expectations.

## **Recommendation 6: MoH to provide additional support to LHDs and Directors of Training.**

- 6.1 Provide a pre-program workshop between the MoH and LHDs to discuss program expectations and troubleshoot issues.
- 6.2 MoH should host regular meetings during the program to support LHDs to manage issues and share experiences.

## **Recommendation 7: Additional central education sessions should be included for MSOs.**

- 7.1 Develop and implement a regular central education program during the 10-week clinical placement.

**Recommendation 8: Address MSO feedback regarding limited accommodation options in regional NSW.**

- 8.1 Discuss and confirm accommodation options and costs with regional LHDs before the program's start.
- 8.2 Clearly communicate accommodation costs to MSOs before they accept placements.

**Recommendation 9: Expand flexibility of funding for DoTs.**

- 9.1 Provide flexibility for LHDs to use the funding for a DoT (at a minimum of 0.2 FTE) and some administrative support.

**Recommendation 10: Provide additional support to MSOs for employment and Ahpra registration processes.**

- 10.1 MoH to liaise with key stakeholders regarding Ahpra registration for future iterations of the ICRP (from 2025 onwards).
- 10.2 Provide additional educational support to MSOs early in the program to build their job application skills, outline employment pathways in NSW Health and Ahpra registration processes.

# References

## Glossary

<b>DOT</b>	Director of Training
<b>ICRP</b>	IMG Clinical Readiness Program
<b>IMG</b>	International Medical Graduate
<b>MSO</b>	Medical Support Officer
<b>MOH</b>	Ministry of Health
<b>PROJECT TEAM</b>	The team within the Workforce Planning and Talent Development branch responsible for the planning, management and delivery of the ICRP
<b>WPTD</b>	Workforce Planning and Talent Development

## Appendices

### Appendix 1.

#### Selection Process – additional information

##### LHD Expressions of Interest

The EOI requested information on the number of IMGs invited to participate (with a maximum of eight per LHD), the location and speciality of the proposed placement, and the proposed team/departmental structure. LHDs were asked to indicate their willingness to participate in the evaluation following the program's completion.

Eight LHDs submitted a proposal to host a pilot site; five of these were in rural and regional locations and three in metropolitan locations. All the LHDs that submitted a proposal were included in the pilot.

A pilot site selection panel was established to assess the proposals and provide advice on the distribution of MSOs and the wards/units chosen.

The program was intended to provide the IMGs with exposure to a general unit to give them a wide range of experience. Wards/units that were considered appropriate for an MSO to undertake a placement in included:

- General medicine
- Geriatrics
- Emergency medicine
- Surgery
- Intensive care
- Cardiology
- Renal medicine
- Rehabilitation.



Wards/units that were requested as part of LHD proposals and not considered appropriate for an MSO to undertake a placement included:

- Paediatrics
- Anaesthetics
- Obstetrics and gynaecology
- Mental health.

### Directors of Training (DoTs)

Each participating LHD was required to nominate a DoT to be responsible for implementing the ICRP pilot in their LHD and to act as a support for the MSOs and their respective supervisors. The Ministry of Health funded participating LHDs with a DoT position to coordinate and manage the program at each district. Districts with five or more MSOs were funded for 0.4 FTE for DoTs; districts with less than five MSOs received 0.2 FTE for a total of 14 weeks. They were given an additional two weeks to allow time for administrative preparation before the program's start.

DoTs' role was to:

- provide clinical and professional leadership, support, education and supervision to the MSO
- supervise the professional and personal wellbeing of MSOs
- design and monitor the training programs for the MSO to ensure they had the necessary skills and knowledge
- facilitate regular communication between the MSO and supervisors, including issues management and escalation where needed
- ensure the MSO received a site orientation and a structured education program during their term
- ensure that the MSOs received adequate supervision, and work with the supervisors to ensure the provision of constructive professional feedback in the middle and at the end of the program
- work with supervisors and help to develop a PDP to give to the MSO at the end of the program.

### Scope of Practice

The working group, alongside advice from Ministry of Health Legal and Workplace Relations branches, developed an MSO scope of practice which includes:

- participation in ward rounds
- conducting clinical histories and basic clinical examinations
- reviewing and entering notes in the eMR (with a medical practitioner countersignature)
- performing basic procedures under supervision (venepuncture and IV cannulation).

All tasks required supervision of a post-graduate medical officer year 5 or above. If the supervisor assessed the MSO as competent in a task or procedure, they could undertake this task without direct supervision. This required clear direction from the supervisor with a strict scope communicated to the MSO.

### Advertising, Recruitment and Selection Process

A centralised recruitment campaign was coordinated by the NSW Ministry of Health with advertisement via the NSW Health website, social media networks including LinkedIn and through multicultural community networks. It was open for 14 days. Candidates were asked to provide supporting documentation, answer two targeted questions and provide a cover letter outlining how they met the eligibility criteria, which included:

- must be an Australian Citizen, Permanent Resident or have a visa with unrestricted rights to live and work in Australia e.g. refugee visa, partner visa
- must have completed a recognised medical degree (must be provided as part of the application with certified translation)
- must have passed the Australian Medical Council Part 1 exam
- must not have previously worked in Australia as a Medical Officer

## References (Continued)

- must have passed the International English Language Testing System (IELTS) with a minimum score of seven or the Occupational English Test (OET) with a minimum score of B in each of the four components (listening, reading, writing and speaking).

Recruitment software allowed applicants to register, submit their application and the supporting documents, and provide a response to the targeted questions through a single platform.

A total of 360 individuals applied for the 56 MSO positions. Applications that were incomplete or did not meet the essential criteria were culled. A total of 218 eligible applicants were identified. A scoring template was developed with assistance from a member of the working group, and two Ministry of Health representatives were assigned to score 109 applications each. Scoring was based on the completeness of the documentation provided, and the quality of the answers to the selection criteria and to the two targeted questions.

A total of 100 applicants then progressed to interview stage. The recruitment software system allowed for asynchronous interviews to test verbal and written communication skills.

A selection panel was convened with members of participating LHDs and the Ministry of Health team. The panel was made up of five individuals who were each assigned one question to score (this equated to 100 applicants to be scored per panel member). The top 60 candidates were then identified for a total of 56 places. Of the top 60, the bottom-scoring four candidates were placed on an eligibility list as a backup for any candidates who withdrew from the program or could not meet the recruitment check requirements.

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