Special Commission of Inquiry into Healthcare Funding

Statement of Jacqueline Dominish OAM

Name:	Jacqueline Dominish
Professional address:	1 Reserve Road, St Leonards, New South Wales
Occupation:	Director, Health Professional Workforce, NSW Ministry of Health

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

A. INTRODUCTION

2. My name is Jacqueline Dominish. I am the Director, Health Professional Workforce in the NSW Ministry of Health (**the Ministry**). In this role, I am responsible for:

    a. leading and advising on the scope of health professional workforces, workforce modelling and monitoring,

    b. responding to education, training and accreditation impacts on workforce availability, and

    c. identifying opportunities to influence innovation in education and training and models of care across the NSW public health system.

3. This role requires specialist workforce knowledge of health professions, including credentialling and education requirements for medical, nursing and midwifery, allied health, paramedicine, and Aboriginal Health Practitioners.

4. The role of Director of Health Professional Workforce is a relatively new position having been established in August 2023 to lead a multidisciplinary workforce team of 18 people in the Workforce Planning and Talent Development Branch of the Ministry. While the role and Health Professional Workforce Unit (**Unit**) are in their infancy, the current focus is on developing a repeatable methodology for innovative programs to support well designed local pilots of optimised workforce models which could be rapidly evaluated and considered for statewide scaling.

5. Key stakeholders which the Unit engages with include the Agency for Clinical Innovation (**ACI**), Health Education and Training Institute (**HETI**), Clinical Excellence Commission

(**CEC**), Local Health Districts (**LHDs**), Specialty Health Networks (**SHNs**), the Australian Health Practitioner Regulation Agency (**Ahpra**), NSW Ambulance, Universities, Vocational Education and Training (**VET**) sector and, within the Ministry, the Legal and Regulatory Services Branch, Workplace Relations Branch and the Chief Health and Professional Officers.

6. Before commencing as the Director, Health Professional Workforce in August 2023, I held roles in Western Sydney LHD as the Executive Director Allied Health (2018 - 2023), at the Ministry as the Principal Allied Health Advisor (2017 - 2018), at HETI as the Senior Program Officer, Allied Health (2011 – 2017), and at the Institute of Medical Education and Training as Standards, Allocation and Accreditation Network Coordinator (2009 – 2011). Prior to this I worked for 10 years clinically as an occupational therapist in Australia and the United Kingdom. A copy of my curriculum vitae is exhibited in this statement (MOH.0010.0068.0001).

7. I also hold an honorary position as an Adjunct Associate Professor with the University of Sydney, School of Health Sciences, Faculty of Medicine, and Health.

B. SCOPE OF STATEMENT

8. This statement addresses Term of Reference G concerning the current education and training programs for specialist clinicians and their sustainability to meet future needs. This statement also considers applicability to nursing, midwifery and allied health staff and more broadly future opportunities for paramedicine, Aboriginal Health Practitioners, and non-specialist doctors.

9. This statement makes some preliminary comment regarding new models of care and technical and clinical innovations as relevant to my role (Term of Reference H).

C. TRAINING AND EDUCATION ACROSS HEALTH PROFESSIONALS

10. The majority of health professionals complete undergraduate university training to obtain their base qualifications (with some obtaining this in the VET sector such as Enrolled Nurses and Aboriginal Health Practitioners) enabling them to practise as new graduates in the field. In addition to this, a selection of professions such as medical, psychology and pharmacy require a minimum period of internship training following graduation to obtain general registration with Ahpra to practise independently.

11. There are also a number of self-regulated allied health professions which require training programs where there is a combination of on-the-job training and education while being

an employee of NSW Health, undertaken in partnership and with oversight of a professional association or college such as what occurs with genetic counselling and diagnostic imaging medical physicists.

i. Medical training

12. Medical training is generally a highly structured and formal process. Following undergraduate study, medical trainees complete an internship year followed by a year of prevocational training. Upon completion, doctors can apply for vocational programs which put them on the pathway to fellowship with a medical college. These vocational training positions must be accredited by the relevant medical colleges.

13. Fellowship with a medical college allows the doctor to practise as a recognised medical specialist in that particular area.

14. This system is highly structured with multiple stakeholders engaged including the Medical Board of Australia, Australian Medical Council, medical colleges, training networks, HETI, LHDs, and private and public institutions.

ii. Nursing and midwifery training

15. Upon graduation from an accredited training program, nursing and midwifery students are eligible for general registration with the Nursing and Midwifery Board of Australia (**NMBA**) which enables them to undertake independent clinical practice.

16. The pathway to specialisation is generally less structured for nursing and midwifery staff than it is for medical practitioners. Specialisation in nursing and midwifery is driven by individual interest, on the job experience, role availability and education and training programs available at the LHD. For example, a nurse or midwife may be recognised as a Clinical Nursing or Midwifery Specialist based on years of practice and contribution to mentoring and professional development. Other roles, such as Clinical Nurse/Midwifery Consultants or Clinical Nurse/Midwifery Educators require both on-the-job training and/or some form of post-graduate qualification or study.

17. Nurse Practitioners practise at an advanced level and provide a wider range of healthcare services than nurses, midwives, Clinical Nurse Specialists, Clinical Nurse Consultants and Clinical Nurse Educators. As a result, Nurse Practitioners have a formal training pathway in addition to experience and on-the-job training, with post-graduate training and endorsement required by the NMBA.

iii. Allied health training

18. Allied health professionals, such as physiotherapists, occupational therapists, speech pathologists and dieticians, are qualified to undertake independent clinical practice on graduation from an accredited undergraduate training program. Once this occurs, they are then eligible for general registration with their professional national board (if applicable) and/or membership with their relevant professional association.

19. Progression to seniority/clinical speciality within the profession depends on a number of factors. For example, an allied health professional may be appointed to a more senior role as they have satisfied the level of expertise required under the relevant award, there has been a personal grading process (which means the position is graded based on the experience of the individual rather than the role being designated at a particular grade), or a senior clinician role or clinical specialist role has become available. In most cases, these roles require a minimum experience level, and in some situations, completion of further post graduate study to be competitive for the role.

iv. Psychology training

20. Training requirements for psychology differ from other allied health professions.

21. Within NSW Health, psychologists are employed under the Health and Community Employees Psychologists (State) Award.

22. During university training, psychology students require supervised clinical placements.

23. Entry level training requirements for psychologists to be able to practise independently with general registration from the Psychology Board of Australia require completion of 1-year of supervised practice after 5 years of undergraduate study.

24. Psychologists that wish to specialise in an endorsed area of practice such as Clinical Psychology must satisfy the Psychology Board of Australia's requirements through completion of a period of supervised practice of up to 2 years as a registrar.

25. The direct training pathway for Clinical Psychologists (a protected title) includes a 4-year undergraduate degree with honours and a 2-year Master's degree in Clinical Psychology.

26. Students can apply for general registration as a psychologist after successfully completing the Master of Clinical Psychology which is a direct and separate pathway to general registration via the minimum entry level requirements for general psychology.

27. Clinical Psychologist registrars can work independently but require at least 40 hours of clinical supervision per year by a fully qualified Clinical Psychologist to obtain their endorsement. The Psychology Board of Australia requires psychology students and registrars to be supervised by a registered psychologist who has undertaken supervisor training by an approved provider. This includes online and face to face training and assessments and is generally a minimum of 3 days.

28. Approved board supervisors are also required to refresh their training every 5 years by completing at least one board-approved master class.

v. Paramedicine

29. Paramedics are registered health practitioners with the Paramedicine Board of Australia, entering the National Registration and Accreditation Scheme in December 2018. To register as a paramedic, the person needs an undergraduate degree in paramedicine that has been approved by the Paramedicine Board of Australia.

30. Paramedics have capabilities to provide emergency, urgent and non-urgent healthcare care to the community in a variety of settings. They routinely provide health care for the full spectrum of undifferentiated patients (spanning age and acuity) and need to possess the capabilities required to address this range of patients' health and social needs.

31. Within NSW Ambulance, specialist paramedic career pathways exist to support provision of high-quality mobile health services in NSW. NSW Ambulance currently supports the following clinical paramedic specialist roles, which requires completion of specialist pathway programs and a 12-month education program:

    a. Intensive Care Paramedic (**ICP**): specialist clinicians and senior clinical members of paramedic teams. ICPs provide clinical leadership by monitoring clinical practice, assessing, and mitigating risk to patients, improving efficiency and coordination at the point of care, and advocating for patients with high acuity presentations.

    b. Extended Care Paramedic (**ECP**): paramedic specialists with enhanced training, knowledge, and skills in the management of low acuity patients and referral

pathways – spanning presentations ranging from acute injuries to chronic and complex care.

32. NSW Ambulance is currently considering the possibility of microcredentialling standard paramedics in individual procedures to respond to local community healthcare needs.

vi. Aboriginal health practitioners

33. Aboriginal Health Practitioners work collaboratively within multidisciplinary healthcare teams to achieve better health outcomes for Aboriginal people. They work across a range of health care settings including primary care, provide clinical services including immunisation, diabetes care, assessment and screening of physical health and wellbeing, administering and supplying medications, and advocating for and supporting Aboriginal clients.

34. Aboriginal Health Practitioners are registered healthcare practitioners who provide clinical services and patient care with a focus on culturally safe practice for Aboriginal people. To gain registration, practitioners must complete a minimum 18-month Certificate IV program of study approved by the Aboriginal and Torres Strait Islander Health Practice Board of Australia.

35. A priority focus of the Unit is growing the Aboriginal Health Practitioner workforce via expanding training pathways and supporting transition to practise within NSW Health.

D. ROLE OF NSW HEALTH IN ONGOING EDUCATION

36. NSW Health has an ongoing role in education at both a state and LHD/facility level. In addition, HETI provides high quality training and education to clinical and non-clinical staff, trainers, managers, and leaders across the NSW health system. A co-funded model is used where LHDs/SHNs and NSW Health Pathology participate and co-contribute funding for the development of online education and training needs (called the **District HETI model**).

37. The District HETI model is designed to ensure system-wide collaboration in the development of online learning resources to enhance the knowledge, skills, and capability of the NSW Health workforce. It is designed to ensure that best practice statewide resources are efficiently developed, and effort is not duplicated at health organisations.

38. Individual clinicians have a responsibility to remain up to date with current practice and be engaged in a process of lifelong learning. This is a mandatory requirement of Ahpra registered professions.

39. Communities of practice (such as, for example, particular medical specialties) also play an important role in the ongoing education of clinicians through enabling networking, sharing of best practice, and access to in-services and education provided by externally invited experts. These communities of practice may be organised at a LHD/SHN level, across LHD/SHNs between similar professional groups, or facilitated at a state level by central agencies such as the ACI, HETI, or Ministry.

40. Education (outside of mandatory training) is part of the responsibility of managers and leaders and should be responsive to local service needs and individual learning goals to improve clinician capability, experience and the quality of care provided to patients.

41. Some professions like nursing and midwifery have designated clinical educator roles which provide a career path for some nurses and midwives to take. These roles also provide a clearly designated resource for the nursing and midwifery workforce to access ongoing education.

42. Allied health also has some clinical education roles focused on students, and health professional educator roles focussed on staff. However, they are not as widespread as in nursing and midwifery. These responsibilities generally fall to senior allied health clinicians as part of their existing roles to balance with clinical caseload responsibilities.

E. SCOPE OF PRACTICE

43. There is no universal definition for "Scope of Practice" in Australia, with professions applying it differently.

44. There are several barriers that exist in the public health system in NSW which impact on the ability of clinicians to operate to their top of scope. These include:

    a. Workplace culture and the attitudes of individual clinicians and managers which can prevent collaborative and transdisciplinary working. This may be driven by historical beliefs, a lack of knowledge, understanding or appreciation of another health professional's training, qualifications and capabilities or simply fear of losing professional identity through perceived role erosion by others.

b. Policy and legislative requirements (such as regulation of drugs) have not kept pace with the changing landscape of health service delivery and the evolution of health professional training, practice and capability. While this is a recognised barrier, states like NSW do have the ability to modify existing policy and state based legislation to enable pragmatic change to improve service delivery where evidence supports this and appropriate governance is in place.

c. Concerns about patient safety (real or perceived) can hinder top of scope practice due to complexities around changing and implementing systems at a local or state level in a timely manner and bringing other clinicians on that journey. It is important to listen to people's genuine concerns, seek to understand them and address clinical governance requirements in a robust manner to instil confidence and ensure patient safety.

d. In some cases, employment conditions arising from industrial agreements may be a barrier to implementation of innovative models of care such as the inability to be on call, undertake shift work or be employed in a specific way. An example of this is the historical employment of paramedics by NSW Ambulance rather than by LHDs limiting the practice settings in which they can work. Collaboration between industrial associations, Workplace Relations Branch and professions are critical to support the agenda of top of scope practice and implementation of innovative models of care.

i. Federal Scope of Practice review

45. A review to redesign primary care was announced in the 2023-2024 Federal Budget and forms part of the Australian Government's response to the Strengthening Medicare Reform Taskforce. Primary health care is often the first point of contact individuals have with the health system and encompasses a broad range of professions and services including general practitioners, allied health professionals, nurses, optometrists, community pharmacists and dentists. The review titled "Unleashing the Potential of our Health Workforce – the Scope of Practice Review" (**the Review**) is being led by the Commonwealth and is currently in progress. The final report and implementation plan is due in October 2024.

46. The Unit is coordinating the statewide response for NSW Health for the Review. The Review has been a significant opportunity for NSW Health to contribute to the process

of identifying and addressing barriers experienced by primary health care professionals limiting their ability to work to their optimum scope of practice.

47. Although the focus of the Review is on primary care, the general findings from the Review are expected to be transferrable to the NSW public health system and will likely assist in informing ongoing statewide reforms.

ii. Examples of support to top of scope practice

48. The overarching goal of the Unit is to empower clinicians and LHDs/SHNs to progress innovation and put ideas into action without the need for overengineering solutions. This is while also recognising the need for more in-depth involvement from the Unit and central agencies to unlock more complex barriers and enable genuine transformational and sustainable change across the system (MOH.0010.0029.0001).

49. The Unit supports LHDs/SHNs to address barriers to supporting top of scope of practice through:

    a. Provision of advice to individual clinicians within a LHD/SHN or NSW Health Agency/Pillar. The role of the Unit is to consider the information, broker further advice if required, and then provide confident advice and direction on whether to proceed. This occurred recently where a LHD was in the process of redesigning allied health roles within an outpatient fracture clinic however was becoming repeatedly impeded by concerns raised with Medicare billing practices and how this would restrict top of scope practice of non-medical staff. The Unit was able to address these concerns, provide education and clear direction, policy advice and permission to proceed.

    b. Assistance with addressing identified barriers to progress a particular piece of work, to assist with an assessment of whether a regulation or policy amendment is required or to fund/broker access training to enact a strategy. An example is the current Aboriginal Health Practitioner Influenza Vaccination Pilot in Western NSW LHD and Far West LHD whereby the LHDs are supporting increased immunisation against influenza for Aboriginal people and the Ministry is providing access to training for key staff.

    c. Formalised processes to address statewide priorities where there is a significant degree of complexity due to the number of stakeholders involved and the scale of change which is required to ensure impact. For example, the ACI in partnership with the Unit is leading a project called the Integrated Paramedic Workforce Project which

aims to pilot the integration of paramedics within multidisciplinary teams outside of NSW Ambulance settings. The Unit has assisted with robust stakeholder engagement and provision of advice to enable unlocking of barriers to ensure paramedics will be able to operate with an optimised scope of practice. Pilots are currently under development at Mudgee Hospital Emergency Department and the Rapid Access Clinic/Hospital in The Home service at Wagga Wagga Hospital.

F. PRIORITIES FOR DEVELOPMENT OF FUTURE MODELS

50. NSW Health has identified priorities to develop further workforce models as part of consultation for the Future Health Strategy Outcome 4. The Future Health Strategy enables the implementation of the Health Professionals Workforce Plan 2022- 2032 (SCI.0001.0043.0001).

51. NSW Health workforce leaders and advocates agreed that there are four key opportunities to address which will unlock the potential of the future health workforce:

    a. Improve access and accuracy of statewide workforce data to enable evidence-based and service workforce planning.

    b. Build an agile virtual health workforce capable of delivering quality care across NSW.

    c. Modernise employment arrangements to enable delivery of new care models and new ways of working.

    d. Design, pilot, and scale best-practice multidisciplinary models for better patient outcomes across a range of settings.

52. To support the achievement of items 51(c)-(d) above, a number of opportunities were identified for further investigation, including scaling of evidenced multidisciplinary team (**MDT**) models which have been evaluated with good outcomes but have had limited scaling. These MDT models are discussed in further detail below.

i. Rapid Assessment, Intervention and Discharge – Emergency Department (RAID-ED)

53. RAID-ED is a transdisciplinary model implemented in Western Sydney LHD Emergency Departments. This Model of Care (**MoC**) includes a rapid response seven-day, extended hours service, with a team of physiotherapists, social workers, and occupational therapists providing timely allied health multidisciplinary treatment at the ED front door immediately after triage.

54. This MoC allows health professionals to work to full scope of practice, reduces workload for the acute care sector, increases health professional utilisation and retention and creates efficiencies at a system level. The primary contact allied health practitioners work in a transdisciplinary MoC at top of scope practice and use assessment and treatment skills which are shared across the disciplines. This enables a more efficient and cohesive service and improved experience for the patient.

55. The pilot which was run from October to December 2020 demonstrated 1,402 patients seen in the ED, of which 63% arrived by ambulance. The time to be seen improved by 60.6 hours with 61.8% of patients seen by RAID-ED directly discharged from ED (vs 38.2% of patients admitted). Patients seen by RAID-ED were also shown to have a lower 48-hour re-presentation rate.

56. The table below illustrates the efficiencies made during the three-month RAID-ED pilot which continued to permanent implementation at Westmead and Blacktown Hospitals:

KPI	Westmead	Blacktown
Transfer of care (average)	Improved by 3%	Improved by 6%
Emergency Treatment performance (average)	Improved by 3%	Improved by 7%
ED average length of stay	Improved by 34 minutes	Improved by 74 minutes
Stays over 24 hours	Oct-Dec 2019 = 732 Oct-Dec 2020 = 30	Oct-Dec 2019 = 567 Oct-Dec 2020 = 8
Admission rates	Decreased by 1.5%	Decreased by 0.3%
48 hour representation	2.2%	2.1%

ii. Quick Access Response Team (QuART): Emergency Department primary contact Allied Health Professionals

57. QuART is a transdisciplinary team of allied health staff, based in Shoalhaven Hospital and Wollongong Hospital, which provides a short intensive two-week service to patients in their homes. It focuses on providing out of hospital care to prevent admission, with a transdisciplinary education program locally designed as the enabler. While the teams consist of a variety of allied health professions to maximise the breadth of skills of the workforce, team members are trained in core competencies across professions to build capacity and enable more comprehensive care delivery for each interaction.

58. The primary aim of the program is to provide coordinated allied health support and intervention to enable the avoidance of an imminent admission; or support early discharge for patients requiring urgent medical investigation/interventions in the first 72 hours of admission.

59. Recent evaluation demonstrates that of the 206 patients who were accepted into the program over the period of the pilot, 50% came from the Aged Services Emergency Team (ASET). Most QuART activity (60%) related to admission avoidance (patients referred to the program from ED). Most QuART patients (92%) were discharged safely with some requiring referral for follow-up allied health services. Average acute admission cost savings (NWAU for acute services 2019/20) relating to admission avoidance was $863,500 over the six-month period of the pilot. The patient experience of the program was overwhelmingly positive.

iii. Partnered Pharmacy Medication Charting (PPMC)

60. PPMC is a model of care that involves a credentialed pharmacist and medical officer having a collaborative discussion about current medical and medication related problems, following which a medication plan is made. This results in significantly less medication errors, improved patient safety and reduced healthcare costs.

61. Traditional models of care involve doctors assessing a patient, which includes a medication history, and charting and signing each medicine in the medication chart. This may also involve a pharmacist undertaking a medication history and reconciliation after the medicines have been prescribed.

62. In the PPMC model of care, the medical officer remains the authorised prescriber, but the medication plan is made in consultation with the pharmacist. The doctor is only required to co-sign the patient's medication plan documented as a progress note, where the credentialed pharmacists chart the medications in the medication chart without individual co-sign.

63. There is strong evidence to support this collaborative approach to medication prescribing between the doctor and the pharmacist. Research undertaken in Victoria demonstrates a reduction in the number of patients with at least one medication error from 19.2% to 0.5% and a reduction in average length of stay from 6.5 to 5.8 days with collaborative prescribing. This translated to an average saving of $726 per PPMC patient.

64. PPMC has become common practice in several other jurisdictions. Following a successful pilot at Royal North Shore Hospital in Northern Sydney LHD, the PPMC model will be scaled and trialed across LHDs/SHNs. The project is led by the Chief Allied Health Officer in partnership with the Health Professional Workforce Unit.

65. Undertaking a medication history and medication reconciliation is a core skill within a pharmacist's scope of practice. To implement PPMC, LHD/SHNs will be required to credential their pharmacists, which involves online learning modules, workplace-based assessment and a clinical examination.

iv. Further examples where scope of practice has been enhanced for staff within NSW Health with training and education as one of the enablers

66. **Remote X-ray Operators**: Diagnostic Radiography can only be performed by a person licenced to operate irradiating apparatus under the *Radiation Control Act 1990.* The Environment Protection Authority (**EPA**) provides opportunity for Remote X-ray Operators to obtain a Limited Licence enabling them to deliver a limited range of acute diagnostic radiography services in small rural and remote communities in the absence of a radiographer. To obtain a licence in NSW, health professionals including medical practitioners, registered nurses, and physiotherapists, must complete an accredited training program.

67. Up until December 2021, the University of Newcastle (**UoN**) delivered the Limited Licence radiography course, which was only available to nurses and General Practitioner Visiting Medical Officers in rural locations. The closure of the UoN course led to NSW Health partnering with HETI to develop the NSW limited licence radiography course. HETI has now been accredited by the EPA to coordinate the delivery of the NSW Limited Licence radiography course which is available on My Health Learning to rural LHDs that benefit from having access to Remote X-ray Operators.

68. An approach was made to the EPA to expand the licensing arrangements to include NSW Health physiotherapists, occupational therapists and podiatrists, however the EPA committee has provided approval for physiotherapists only to be included in the licensing arrangements at this stage. Once the Limited Licence has been successfully piloted with physiotherapists there may be an opportunity to revisit the request with the EPA to expand to other professions.

69. **Emergency Care Assessment and Treatment (ECAT) program** is an example of NSW Health supporting nurses to work to their optimal scope of practice in Emergency

settings. ECAT is a statewide, co-designed program that aims to standardise nurse-initiated emergency care, reduce unwarranted clinical variation, and improve patient experiences and staff satisfaction.

70. ACI and its pillar partners have led the development of 73 clinical ECAT Protocols covering a range of adult and paediatric presentations, prerequisite education modules, an education and recognition of prior learning guide, a NSW Health emergency nursing capability framework and a policy directive.

71. The ECAT Protocols enable and authorise nurses to order pathology tests and medical imaging as well as initiate treatment and medications based on nursing clinical assessment. This ensures timely care in the absence of medical officers or nurse practitioners, allowing nurses to utilise their knowledge and assessment skills to initiate emergency care. The ECAT Protocols are supported by an Emergency Nurse Capability Framework, education modules and recognition of prior learning.

72. ECAT will support nurses to transfer their skills across LHDs in emergency settings and enable the transfer of a skilled workforce.

73. The recently established ED Taskforce has endorsed and approved the ECAT Program model for rollout across the NSW public health system as part of its role in leading ED strategic direction in NSW.

74. **COVID-19:** During the COVID-19 pandemic, there was a shortage of intensive care/critical care nursing with the appropriate skill set to manage the volume and complexity of admitted patients, and a shortage of Nurse Immunisers required for a mass vaccination effort. To enable skilled staff to be deployed into areas of greatest need, the Ministry supported training of staff to optimise the use of available workforces to meet community need.

75. **Physiotherapy Cardiorespiratory ICU training**: NSW Health, in partnership with HETI, worked with the Australian Physiotherapy Association to develop and deliver a two-day virtual interactive weekend training to upskill up to 360 NSW Health physiotherapists. The purpose was to support physiotherapy staff learning to function effectively in health district ICUs with the increasing cases of COVID-19. The content had a strong focus on weaning off ventilators, as this had been identified as a priority to saving lives.

76. **Critical care nursing**: LHDs/SHNs undertook local upskintegrilling programs, where 2327 registered nurses undertook upskilling to support the increased workforce needs in

ICUs. The Ministry in collaboration with the Australian College of Critical Care Nurses funded the development of Critical Care online modules.

G. ADVANTAGES, CHALLENGES AND FURTHER OPPORTUNITIES

i. Advantages

77. The COVID-19 pandemic demonstrated the role of collective urgency in encouraging and implementing innovative workforce models. NSW Health demonstrated the ability to leverage this latent flexibility across the system to adapt ways of working and respond to changing needs of the population to meet service demands aligned with a common goal.

ii. Challenges

78. There is a need to introduce a narrative across the NSW Health system about what is understood by the terms scope of practice, working to top of scope and enabling optimisation of workforce models through transdisciplinary practice.

79. Attitudes, professional guarding behaviour, and cultural differences between professions and within multidisciplinary teams is a major barrier to enabling top of scope practice. There is a need to start having hard conversations in a supportive but transparent and robust manner, focussed on the problems we need to solve with a collective sense of urgency and articulation of a single compelling reason to act as a collective. Executives at all levels must lead and reinforce new ways of working as must senior clinical leaders with support from central agencies such as the Ministry, ACI, CEC and HETI.

80. Change management to implement new models and ways of working must genuinely provide for time to engage with people in discussion to understand individual needs and concerns and facilitate a respectful dialogue between professional groups. This will also provide a forum to challenge myths but also genuinely address patient safety and clinical governance concerns (real or perceived) to enable initiatives to progress.

81. In progressing the above, there is a need to provide "plug and play" tools and resources from the centre to enable standardisation and robust professional and clinical governance while also enabling local independence and innovation to progress new ways of working. The balance between robust design without unnecessarily overengineering development of solutions to enable timely and pragmatic implementation by LHDs/SHNs will be important.

iii. Opportunities

82. There is a particular opportunity to progress this agenda with non-medical professions such as nursing, midwifery, allied health, paramedicine, and Aboriginal Health Practitioners due to the breadth of underutilised scope of practice available within and across disciplines and within existing regulatory and professional frameworks.

83. NSW Health can capitalise on themes emerging from the Review and the feedback already provided to the Ministry by LHDs/SHNs and other NSW Health Agencies to progress reforms of the NSW public health system within its control, independent of work occurring at the Commonwealth level.

84. NSW Health can consider changes to state-based legislation and authorising instruments to unlock scope of practice where its deemed appropriate. This can be enabled by standardised education and training to implement new ways of working, innovative workforce models and models of care that will benefit the population and improve clinician experience.

85. There is an opportunity to invest in the capability of the future generation of clinical leaders who will be instrumental in changing attitudes towards new ways of collaborative working and the development of transdisciplinary models of care which improve patient outcomes and clinician experience. This requires individuals to be confident in having robust conversations in a respectful manner and approaching their colleagues from other disciplines with a sense of curiosity and admiration rather than with scepticism and synoecism which is common professional guarding behaviour. There are some examples of innovative leadership programs and activities currently being run in LHDs.

86. There is an opportunity to further empower clinicians and LHDs to be innovative in thinking about progressing the agenda of top of scope practice through developing and trialling new workforce models to deliver models of care with support and advice available from the Unit.

87. A recent example is the Advancing Practice Colloquium held by Western Sydney LHD involving representatives from across the Ministry, Universities and local executive leadership and clinicians. In addition, Churchill Fellow, Professor Beverley Harden MBE, National Lead Multiprofessional Advanced and Consultant Practice and Deputy Chief Allied Health Professions Officer, NHS England was invited to present in partnership with the Director of Health Professional Workforce to outline the current landscape and opportunities to unlock scope of practice barriers to advance development of innovative ways of working and new models of care involving allied health professionals working to

top of scope. This provided another forum for robust and progressive discussions to be held about opportunities to work collaboratively across disciplines to improve patient care, ensure workforce models were optimised and clinician experience improved.

88. There are opportunities to reach out globally to other health systems to learn from their experiences while NSW Health progresses local reforms. A strong relationship has been established between the Workforce Planning and Talent Development Branch and NHS England through Professor Harden. This collaboration has already provided invaluable networking opportunities and connections with NHS England executives and profession specific colleges and associations to assist NSW Health with ongoing background research and planning in progressing education, training and workforce development strategies.

89. There is an opportunity to address the professional development and career pathways of non-specialist doctors. Service registrars and career medical officers are non-specialist doctors who are not on a vocational or prevocational training pathway. These doctors currently provide significant services to patients and effectively keep hospitals running 24/7 and require the appropriate skills to deliver these services. Many are still working towards entering specialty training; however, we know a significant portion of them do not want to enter specialty fellowship. This presents an opportunity to further strengthen access to education and training to meet specific learning goals and skill development for this group of doctors. Additionally, we would further develop their roles and responsibilities alongside a sustainable non-fellowship career pathway. This has been highlighted in the national medical workforce strategy as a priority however there is an opportunity for NSW Health to consider how we might design something that will meet the needs of our doctors and the NSW public health system. All registered doctors are required to undertake CPD as per registered allied health, nursing and midwifery, paramedicine, and Aboriginal Health Practitioners.

90. Investigating options for standardisation of microcredentialing across professions relevant to specific areas of practice would be of benefit. This would provide centrally developed tools and resources which could then be accessible to LHDs/SHNs to undertake appropriate credentialling locally.

91. The Future Health Strategy - Strategic Outcome Four has specifically highlighted the need to grow the Aboriginal Health Practitioner workforce and identify opportunities for Aboriginal Health Practitioners to work in new multidisciplinary models of care across a variety of settings and services. In addition, there is a need to develop workforce

modelling for Aboriginal Health Practitioners which must be informed by genuine stakeholder consultation, leadership, and advice from Aboriginal Health Practitioners themselves. In considering the support required for this clinical workforce to assist with its growth, retention, and emergence of practice into new areas such as the ED, workforce development enablers are required including, professional governance models, sample role descriptions, scope of practice requirements, authorising instruments for administration of medication and wrap around supports including clinical supervision and cultural mentoring.

92. Initial work has been undertaken by the Centre for Aboriginal Health and the ACI in partnership with the Aboriginal Workforce Team to develop a Principled Model of Care for Aboriginal Health Practitioners in the Emergency Department. Further work will be required by the Aboriginal Workforce Team, Health Professional Workforce Unit to support these stakeholders and LHDs/SNs to implement the model via enacting workforce strategies as outlined above, in addition to overall development of the Aboriginal Health Practitioner workforce pipeline.

93. Workforce Planning and Talent Development Branch is undertaking a program of work to establish the Aboriginal Health Practitioner profession as a fourth clinical pillar of the NSW Health system alongside medical, nursing and midwifery and allied health. To support this work, an Aboriginal Health Worker and Practitioner Workforce Advisor within the Aboriginal Workforce Team of the Unit has been established.

94. The Aboriginal Health Worker and Practitioner Workforce Advisor will play a critical role in establishing principles of professional and clinical governance, systems of support to enable practice from a clinical and cultural perspective and advise on development and implementation of new models of care across a variety of settings. The role will also work as part of/and in collaboration with the multidisciplinary team in the Unit including workforce modelling, nursing and midwifery, allied health and medical on initiatives and projects with a multidisciplinary focus.

WSLHD Fostering Leadership Across Systems in Health (FLASH) Program

95. To address some of the barriers to top of scope practice there is an opportunity to focus on influencing the intrinsic and interpersonal human factors that make it difficult for innovative models of care and transdisciplinary working to be conceptualised and implemented in earnest.

96. For example, in Western Sydney LHD it was identified that future clinical leaders across all professional groups need to be positive agents for change, approach problems with curiosity, collaboratively and with a thirst for innovation. Critical to this is understanding the value that their multidisciplinary colleagues bring to improving patient care and the impact that these changing attitudes can have on organisational culture and future workforce models. Learning from, with and about each other through interprofessional learning and practice is a concept currently encouraged in the undergraduate space.

97. Western Sydney LHD has incorporated this concept through the development and refining of a clinical leadership program called FLASH (Fostering Leadership Across Systems in Health) to embrace transdisciplinary practice and ways of working to lead to better clinician experiences and patient outcomes. FLASH is an innovative program which has been running for the past 4 years incorporating Medical & Dental, Nursing & Midwifery, Health Management Interns and Allied Health Professional staff.

98. The FLASH program aims to support aspiring clinician leaders in attaining skills required to effectively drive improvements within the health system. High-quality, safe patient care and staff engagement link strongly to leadership. Formal education around leadership is lacking within health professional training and FLASH directly addresses that gap.

99. The FLASH program is based around the Australia Health LEADS Framework for leadership education. The clinical groups targeted are outlined below:

Medical/ Dental	Nursing & Midwifery	Allied Health	Other professions
Consultants in their first 1-10 years of independent practice	Nurse Practitioners	Senior clinicians – Level 3 & 4	Health Management Interns (first year)
Advanced Trainees	Clinical Nurse Consultants	Senior clinicians – Level 2 where experience of size of the dept applies	
Fellows – clinical or research	Clinical Midwifery Consultants		
General Practitioners	Nurse/ Midwifery Educators		
Dentists	Clinical Nurse/ Midwifery Specialist 2		

100. Over the past four years, 337 staff have been enrolled in the program and offerings have also been extended pending funding support to Sydney Childrens Hospitals Network and Northern Sydney LHD.

101. FLASH has enabled cross-network connections and collaboration for participants. Participants have reported more confidence in communicating and advocating for themselves and their patients and that collaborations between professions have resulted in innovative multidisciplinary teamwork across the LHD. This includes creation of interprofessional learning opportunities within specialty groups, setting up new services, developing new models of care and undertaking joint research projects.

Jacqueline Dominish

Witness:

5/7/24

Date

5/7/24

Date