Special Commission of Inquiry into Healthcare Funding

Statement of Professor Peter Hockey

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1. This statement made by me accurately sets out the evidence that I would be prepared, if necessary, to give to the Special Commission of Inquiry into Healthcare Funding as a witness. The statement is true to the best of my knowledge and belief.

2. This statement is provided in response to a letter of 23 May 2024 issued to the Crown Solicitor's Office and Issues Paper 1/2024 issued by the Inquiry and addresses the topics relevant to my role.

A. INTRODUCTION

3. I am the Executive Director for Quality and Safety for Western Sydney Local Health District (**WSLHD**). I have been in this role since May 2023. A copy of my curriculum vitae is exhibited to this statement (**MOH.0010.0028.0001**).

4. In this role, I oversee WSLHD's Clinical Governance Unit and Research and Education Network (**REN**). The Education Unit based within REN oversees WSLHD's clinical education for medical officers, medical students, nursing and allied health staff and students, as well as placements of medical graduates and clinicians. Additionally in my Education portfolio, I am responsible for supporting functions which are necessary for contemporary education at WSLHD, including:

   a. leadership development of clinical staff through an organisation wide suite of programs called FLASH (Fostering Leadership Across Systems in Health);

   b. assessing and monitoring education quality;

   c. professional support to individuals and teams in difficulty;

   d. supporting the recruitment and onboarding of International Medical Graduates (**IMGs**); and

   e. supporting WSLHD's Director of Education.

5. I was previously a Postgraduate Dean at Health Education England (the governmental arms-length body responsible for workforce planning and education), where I had extensive experience of supporting and placing learners and educators across the South of England.

B. CLINICAL PLACEMENTS

6. I set out below the figures concerning the number of placements offered and the total number of placement work hours for a particular year in WSLHD across particular disciplines:

Year	Medicine		Nursing		Midwifery		Allied Health	
	Total placement hours Utilised	Total Number Students assigned to placements	Total placement hours Utilised	Total Number Students assigned to placements	Total placement hours Utilised	Total Number Students assigned to placements	Total placement hours Utilised	Total Number Students assigned to placements
2018	417156	713	430240	3020	17992	51	190276	980
2019	675208	764	499832	3174	21328	50	207052	1006
2020	353528	661	441080	2808	19488	58	197244	882
2021	466152	789	427776	2729	17768	50	209212	831
2022	450612	728	478320	2925	17936	52	221528	939
2023	393048	713	417752	2512	19416	66	227510	973

7. WSLHD offers placements to university medical students from the University of Sydney, Notre Dame and Western Sydney University. Medical graduates are employed in WSLHD from many different universities after graduation from medical school.

8. The process of placing people in training positions is manual and I consider that there are likely to be significant efficiencies in improvements to the automation of such a system.

9. In terms of international medical students undertaking elective placements within WSLHD, students are placed within WSLHD in conjunction with the university host (for example, the University of Sydney). In such circumstances, WSLHD completes all the administrative duties required for such placements and does not receive funding from universities to do so.

C. OPPORTUNITIES

(i) Education and training

10. Training opportunities for doctors, nurses/midwives and allied health professionals are traditionally thought to only occur in a hospital setting. In my view, the system and LHDs within the system are not leveraging significant opportunities outside hospitals to train people (for example, Hospital in the Home services, Aged Care Facilities, Community

Clinics), being the places where most illness and treatment occurs. I consider that this perpetuates a belief in the NSW workforce that meaningful work must be done in a hospital.

11. In my view, it is simplistic to send people from metropolitan areas to rural areas for short periods of time in order to enhance education training in rural locations. Rather, the system needs more incentives for people to work and live in rural areas. From my time working in the United Kingdom in 2016-2019 as Postgraduate Dean, simple incentive programs such as funding grants were successful in feeding training positions in rural areas. Such situations also require consideration of how to further incentivise senior medical staff to train clinicians in such areas and support such senior medical staff in sometimes isolated conditions.

(ii) Workforce planning

12. In my view from an LHD, the level of workforce planning in NSW could be improved. The numbers of training positions are largely driven by universities or other education institutes who offer medical, nursing and/or allied health degrees. LHDs have little to no ability to influence graduate numbers. For example, in WSLHD there is currently a high demand for radiation therapists. The closest university that offers a radiation science degree is the University of Newcastle, whereas previously the University of Sydney offered a similar degree. There are obvious challenges with attracting radiation therapists to work in WSLHD if they reside in Newcastle. Another example is the oversupply of other groups of clinicians, such as physiotherapists and pharmacists. Workforce planning needs to occur at least at a state level, or ideally at a national level so that Commonwealth supported positions can be used to drive in-demand workforces or specialities.

13. There is also an opportunity to develop earlier training opportunities to expose learners to in-demand clinical services such as primary care and psychiatry. In my view, the development of specific generalist clinical skills, such as those performed by a general practitioner or hospital specialists involved in the management and diagnosis of acute presentations, is an integral skill in both the acute and primary care settings. In relation to mental health, it is my experience from my previous role as a Postgraduate Dean in the UK that mandating an early psychiatry training block for junior clinicians exposes them to a wider understanding of mental health issues and what role a psychiatrist can play in treatment options for all patients. If training programs incorporate early exposure to in-demand services, it is my experience that this can then facilitate the ongoing

practice and choice of specialty for clinicians in those areas. I am also of the view there is a role for a hospital generalist, however, to date I have only seen this role widely utilised in the United States of America.

D. ROLE OF UNIVERSITIES, HETI AND COLLEGES IN CLINICIAN TRAINING

14. In relation to the role of universities in clinical training, Westmead Hospital is a good example of how universities can have a big presence and impact on patient care in hospitals. The University of Sydney makes significant investments in research and placements at Westmead Hospital, making it an attractive place to work as there are research, education, and academic opportunities available.

15. Similar integrations between universities and hospitals have occurred to a certain extent in rural areas, often via the establishment of rural clinical schools. Such schools are often attractive to senior medical staff. However, I consider that as a system the relationship between LHDs and universities is not always leveraged as well as it could be. As an example of leveraging, WSLHD has done well in establishing conjoint professorial appointments with the University of Sydney, University of Wollongong and Western Sydney University, not just in medicine but in allied health, nursing, public health and pharmacy.

16. In relation to the role of the Health Education and Training Institute (**HETI**) in clinical training, it is effectively a college for post-graduate year (**PGY**) 1 and PGY2 doctors. In my view, it does not leverage available opportunities as much as it could. For example, it could drive placements and appointments in interesting and diverse fields such as Clinical Governance, Finance, and smaller specialities (for example, Clinical Genomics). However, the reliance on provision of day-to-day clinical service by doctors in these early postgraduate years makes it difficult to rotate these doctors away from hard-pressed clinical areas. Exposing early career doctors to the breadth of healthcare would better prepare clinicians for the types of non-clinical leadership roles many of them will undoubtedly need to undertake.

17. While my role at WSLHD is not involved in the accreditation process, I am aware from my previous professional experience in the United Kingdom that the accreditation

process is different there. In the United Kingdom, the College role is limited to setting the standards and examinations. In my view, this helps clarify the role of the College.

Professor Peter Hockey

Witness: AMY MALIK.

10/7/2024

Date

10/7/2024

Date