Special Commission of Inquiry into Healthcare Funding

Statement of Richard Griffiths

Name:	Richard Griffiths
Professional address:	1 Reserve Road, St Leonards, New South Wales, 2065
Occupation:	Executive Director, Workforce Planning and Talent Development

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 (**Inquiry**). The statement is true to the best of my knowledge and belief.

A. INTRODUCTION

2. My name is Richard Griffiths. I am the Executive Director, Workforce, Planning and Talent Development (**WPTD**) in the NSW Ministry of Health (**MOH**). WPTD is responsible for developing, facilitating and evaluating health workforce strategies across the NSW health system to support the health workforce in delivering improved health outcomes for communities across NSW. WPTD also works with the Commonwealth and other key stakeholders to understand the needs of the future health workforce and works with these stakeholders to improve workforce supply and distribution. WPTD also has an important role in providing leadership, information, education and support to health services.

3. Before commencing as the Executive Director, WPTD in January 2019, I was previously employed in the NSW Police Force, TAFE NSW and the NSW Health system in human resources and industrial relations roles. A copy of my curriculum vitae is exhibited to this statement (**MOH.0010.0280.0001**).

B. SCOPE OF STATEMENT

4. This statement is provided in response to letters of 23 May 2024 and 1 July 2024 issued to the Crown Solicitor's Office. It addresses the issues contained in Issues Paper 1/2024 relevant to my role, Term of Reference F, concerning the current capacity and capability of the NSW Health Workforce to meet the needs of patients and staff, and Term of Reference G, concerning the current education and training programs for specialist medical clinicians, nursing, midwifery and allied health staff and their sustainability to meet future needs. I have reviewed the data report of Rian Thompson dated 16 July

2024 (**NSW Health Workforce Data Report**) and the data contained in that report has been used as a source for this statement.

C. CURRENT POLICIES, PROCEDURES AND GUIDELINES

5. MOH sets statewide workforce frameworks, policies and guidelines which all NSW Health agencies must follow, and a number of Local Health Districts (**LHDs**) and Specialty Health Networks (**SHNs**) have local policies and guidelines which adopt these for a local setting. The key plans and policies relevant to workforce planning and talent development are:

   a. The *NSW Health Workforce Plan 2022 – 2032* (**SCI.0001.0043.0001**).

   b. The *NSW Health Workforce Plan 2022 – 2032 Supplementary Plan* (**MOH.0010.0275.0001**), which assists NSW Health agencies to translate system priorities into local actions.

   c. *NSW Health Workplace Culture Framework* (2011) – currently under review and will be replaced by the *NSW Health Culture and Staff Experience Framework* (2024) (**MOH.0010.0278.0001**).

   d. PD2023_24 *Recruitment and Selection of Staff to the NSW Health Service* (**MOH.0010.0064.0001**).

   e. *NSW Health Talent Strategy* 2022 – 2032 (**MOH.0010.0271.0001**) and *Talent Strategy Implementation Plan* (**MOH.0010.0272.0001**).

   f. PD2022_049 *Student Placements in NSW Health* (**MOH.0010.0262.0001**).

   g. IB2021_025 *NSW Health Student Placement Agreement* (**MOH.0010.0260.0001**).

   h. PD2016_048 *Mandatory Training – Criteria for Approval as a NSW Health Requirement* (**MOH.0010.0261.0001**).

i. PD2019_006 *Employment and Management of Locum Medical Officers by Public Health Organisations* (**MOH.0011.0005.0001**).

j. PD2019_056 *Policy Credentialing and delineating clinical privileges for senior medical practitioners and senior dentists* (**MOH.0010.0320.0001**).

k. PD 2021_007 *Area of Need Program* (**MOH.0010.0311.0001**).

l. PD2024_012 *Rural Health Workforce Incentive Scheme* (**MOH.0010.0314.0001**).

m. PD2023_046 *Aboriginal Workforce Composition* (**MOH.0010.0313.0001**).

n. IB2023_053 *Aboriginal Workforce Composition Minimum Targets* (**MOH.0010.0309.0001**).

o. IB2018_018 *Definition of an Aboriginal Health Worker* (**MOH.0010.0308.0001**).

p. GL2020_005 *Guideline Allied Health Assistant Framework* (**MOH.0010.0307.0001**).

q. *Decision Making Framework for Aboriginal Health Practitioners* (**MOH.0010.0306.0001**).

r. GL2024_009 *Aboriginal Talent Pool Creation* (**MOH.0010.0318.0001**).

s. PD2002_028 *Aboriginal Cultural Training – Respecting the Difference* (**MOH.0010.0312.0001**).

t. IB2024_023 *The Workforce Mobility Placement (WMP) Policy* (**MOH.0010.0310.0001**).

D. NSW HEALTH WORKFORCE DATA

6. As at June 2024, NSW Health workforce comprises 165,634 headcount staff, equating to 139,881 full-time equivalent (**FTE**). The current FTE of the NSW Health Medical, Nursing/Midwifery and Allied Health Workforce as at June 2024 are noted below. The data source from which I have derived that headcount is the Corporate Analytics Data

Warehouse. The Corporate Analytics Data Warehouse is the statewide analytics data storage tool for storing raw data from various corporate systems across NSW Heath agencies located on a single platform to provide optimal reporting solutions.

7. The *NSW Health Workforce Data Report* provides information on the distribution of health workforce by profession.

8. This workforce data includes all NSW Health workforce on permanent, temporary and casual contracts.

9. FTE workforce distribution data needs to be interpreted with caution as it does not allow for a number of factors that explain distribution, such as:

    a. Significant population growth and demographic changes,

    b. Geographical region complexities and networked services,

    c. Cultural and/or Socio-economic complexities,

    d. Specialised clinical services attributed to an LHD may provide services beyond the LHD's organisational boundaries – for example, Tertiary burns, spinal, transplant,

    e. Staffing arrangement of Public Health Services being provided in private-public partnership arrangements or Affiliated Health Organisations.

E. WORKFORCE DATA COLLECTION AND USAGE

Data governance

10. Statewide data assets are data collections, data streams or datasets held by any NSW Health entity and are made up of patient, staff, workforce, organisation, student and financial information collected from across NSW Health.

11. MOH has centralised visibility of workforce data across NSW Health through the Corporate Data Warehouse.

12. Data collection and usage in NSW Health is subject to the requirements of GL2019_002 *NSW Health Data Governance Framework* requirements. The Deputy Secretary People, Culture and Governance and the Executive Director WPTD are responsible for the governance of workforce related data as Data Sponsor and Data Custodian respectively.

Data collection

13. NSW Health collects data from a range of sources, predominantly from the NSW Health payroll system which feeds into the Corporate Analytics Data Warehouse, along with data from the learning management system, static data from the People Matters Employee Survey (**PMES**), financial systems such as V-Money for Visiting Medical Officers (**VMOs**), and the student placement database ClinConnect. The types of data regularly monitored on a monthly basis by WPTD and reported to various governance and performance committees such as the Health System Performance Advisory Meeting and the Health System Performance Monitor Committee include:

    a. Workforce distribution by non-clinical, nursing, allied health, medical and specialty workstreams,

    b. Workforce demographics and diversity, including but not limited to age, gender, disability and Aboriginality,

    c. Workforce distribution by geographical region,

    d. Workforce by FTE categories of full time, part time, casual,

    e. Utilisation of overtime,

    f. Utilisation of workforce not engaged as employees, such as VMO sessional, VMO fee for service arrangements, and some interim agency arrangements,

    g. Utilisation of locum medical officers and agency nurses and midwives,

    h. Staff attrition and retention rates,

i. Utilisation of incentives, scholarships and subsidies (for example rural and tertiary health),

j. Staff satisfaction (for example, PMES, Junior Medical Officer surveys). The NSW Health system participates in the NSW Government's PMES each year, which is a state wide survey of all government sector workers facilitated by the NSW Public Service Commission to measure employee engagement.

14. Workforce data is available to the LHDs through interactive dashboards, offering a range of insights and enabling comparisons between LHDs. These dashboards facilitate self-assessment at the local level. Nominated users in the local People and Culture team and the Chief Executive are able to access information on their own and other health agency performance on a number of metrics such as FTE, headcount, recruitment activity, overtime, leave, retention and workforce diversity information. Access to this information allows Chief Executives and others to review their local performance against others with the intention of encouraging sharing of good practice.

15. NSW Health is limited to publicly available information regarding workforce performance in other jurisdictions that can be used to compare performance, such as industrial award base rates, overall workforce metrics published in jurisdiction annual reports, or publicly reported health metrics. Reliable comparisons are limited due to the inability to obtain sufficient detail.

Analysis of Health Workforce Data

16. Workforce data enables MOH to have oversight of the makeup and distribution of the NSW Health workforce and it being gathered consistently overtime enables identification of patterns and trends that aid in workforce planning and workforce strategy development.

17. MOH collates workforce reports every month broken down by all health agencies for analysis and consideration by the Health System Performance Advisory Meeting and the Health System Performance Monitor Committee. These meetings compare performance of health agencies against a range of targets and indicators, including financial

performance, clinical activity, procurement, workforce, and risk management. Workforce data is collated to identify overall workforce volume across the month, including FTE, leave, overtime, premium labour usage, workforce retention, recruitment activity, workforce incentive spending, and workers compensation performance. Premium labour refers to productive hours paid utilising overtime or agency staff. These meetings can request further investigation into identified matters or areas of concern and inform subsequent conversations between system performance and the LHD to identify any supporting mediations that may be required.

18. MOH uses data on the age distribution of the NSW Health workforce, broken down by geographical region, to determine whether there are any significant differences between workforce demographics of different LHDs as well as how the demographics of staff shift over time. MOH also correlates this demographic data by workforce specialties to identify the seniority of the medical workforce and the trends over time in average separation age by specialty to identify any risks to workforce pipeline in particular specialties by LHD. This data is available locally at the LHD level to People and Culture teams, who utilise this for planning purposes, as well as in the formation of the LHD business plans. Similarly this information is available centrally and has been produced as part of the *NSW Health Workforce Data Report* for the Inquiry. Broadly the shape of the age distribution of NSW Health employees is favourable and skews younger with the median age being around 41.5, around 1.5 years younger than the median age for the broader public sector. A similar distribution is reflected through the LHDs and across the medical, allied health and nursing professions.

19. MOH analyses the size and distribution of the NSW Health workforce. Between 2019 and 2024 the workforce has grown by 13.8% or 16,957 FTE. Metropolitan LHDs grew by 6,407 FTE from 55,593 to 62,000, with the greatest rates of growth occurring in South Western Sydney LHD which grew by 15.9% and Western Sydney LHD which grew by 13.5%. Rural/regional LHDs grew by 13.5% or 6,597 from 48,947 to 55,544 FTE, with Northern NSW LHD recording the strongest growth of 22.7%, Nepean Blue Mountains LHD recording growth of 18.5% and Hunter New England LHD recording growth of 14%.

20. MOH monitors data about the size and distribution of the nursing workforce, the utilisation of overtime by nursing workstream and the engagement of agency staff. This information is used to assess and compare the management of the workforce across and within LHDs. This information also provides insight into nursing workforce supply and availability geographically and can be used to inform tactical and strategic interventions by MOH and LHDs. As at June 2021, overtime constituted about 3.3% of nursing hours worked, equivalent to about 1,120 FTE. In June 2022 the overtime worked by nurses equated to approximately 1,596 FTE or about 3.8% of total Nursing hours worked. From March 2024, the rate of nursing overtime has broadly been lower than that observed during the same time in the COVID-19 pandemic, however rose back up to 3.8% in June 2024.

21. Agency nursing usage spiked at the beginning of COVID-19 as the system scaled up to meet the surge requirements. However, the use and expense of agency nursing has decreased in the following years with the cost of agency nursing decreasing from $63.1m in 2021 to $55.8m in 2023. Measures to reduce the number of premium labour nurses have been implemented and an 11.5% reduction in premium labour has occurred since 2021.

22. MOH uses workforce distribution data broken down by category to determine how the NSW Health clinical workforce, including by specialty, is distributed across the state and whether this has changed over time. Detailed data on the workforce by location, profession and specialty are available and reportable centrally. The distribution of medical specialties by LHD is available at **MOH.0010.0077.0001**. The medical workforce has grown by 13.1% between 2018/19 and 2023/24, and specialist numbers growing by 582 FTE or 15% between 2018/19 and 2023/24 with growth broadly across specialties. However, as reflected in the broader workforce, this growth is not uniform by specialty or by location. NSW Health has a range of different service models across the LHDs, which allow networked access, and virtual access to specialist care while leveraging available local staff across their scope. In addition to this we also support moving patients to specialist and other services to meet their care needs.

23. MOH uses data collected about VMOs to analyse engagement of this workforce across NSW Health, including by specialty and geographic region, to determine whether the use of VMOs has changed over time and whether identifiable trends can be used to predict staffing shortages. The number of VMOs engaged pre COVID-19 was around 6100-6200 per year, however, it is difficult to determine the exact proportion of the workforce that VMOs constitute as these engagements are not based on FTE. During COVID-19 the number of VMOs decreased to 6,054 in the 2020-21 financial year. This figure subsequently rose in both 2021-22 and 2022-23 to 6,476 and 6,732 respectively.

24. MOH gathers data on medical locum engagement spending over time, broken down by geographical area, to identify trends in locum usage and investigate reasons for increased expenditure on locums. The number of locum doctors has increased from a relatively stable figure pre 2021-22. Locum doctors represent a small component of the overall medical workforce, that is, around 3% of medical FTE including overtime in 2018-19 to 4.3% of medical FTE including overtime in 2023-24. This proportion is even lower in metropolitan areas, ranging from 0.54% in 2018-19 to 1.35% in 2023-24. The majority of the locum workforce delivers healthcare services in rural and regional areas, where the proportion of the medical workforce rose from 7.63% in 2018-19 to 9.26% in 2023-24. While the number of locum engagements has risen this remains a small component of the overall workforce at 0.4%, and remains predominantly engaged in rural areas which face greater challenges in accessing medical workforce, particularly for short term cover.

25. MOH analyses data on employment mix to determine how the NSW Health workforce is employed and to identify trends such as increasing casualisation of the workforce, greater utilisation of contract staff, increasing cost of locums and reasons for these trends, broken down by geographical region. The rate of recruitment, and the use of overtime by LHD, is reported each month at a performance advisory meeting. These metrics indicate potential shifts in staffing need and staffing availability, as well as highlighting potential impacts to employee expenses that result from these changes.

26. As at June 2024, 78.6% of the NSW Health workforce was engaged as a permanent employee, 15.9% engaged in a temporary capacity, and 5.5% engaged casually or

through an agency arrangement. Within these groups there is approximately 3% overtime. Splitting out overtime into a single category may result in slight differences in figures. A Treasury Group is an aggregation of positions within the same category of professions. The majority of the Treasury (professional) Groups have a higher than average proportion of permanent employees, the notable exception to this is the medical profession where 26% of employees are permanent. A table providing an overview of the Treasury Groups is exhibited to this statement (**MOH.0010.0315.0001**).

27. Broadly there has not been any significant change in the mix of permanent, temporary and casual employment across the workforce since 2019. Where there have been some changes these have been small amounting to a 0.8 percentage point decrease in temporary employment, and a 0.7 percentage point increase in casuals.

28. MOH gathers data on staff attrition, broken down by work stream, to identify changes over time and predict trends, including by geographical area, to investigate reasons for increased attrition. Workforce Retention measures the percentage of staff that have remained in their role over a preceding twelve month period. NSW Health has historically high retention of its health workforce, and in the lead up to the COVID-19 pandemic, the statewide permanent workforce retention rate was on average 93. 5% (June 2019).

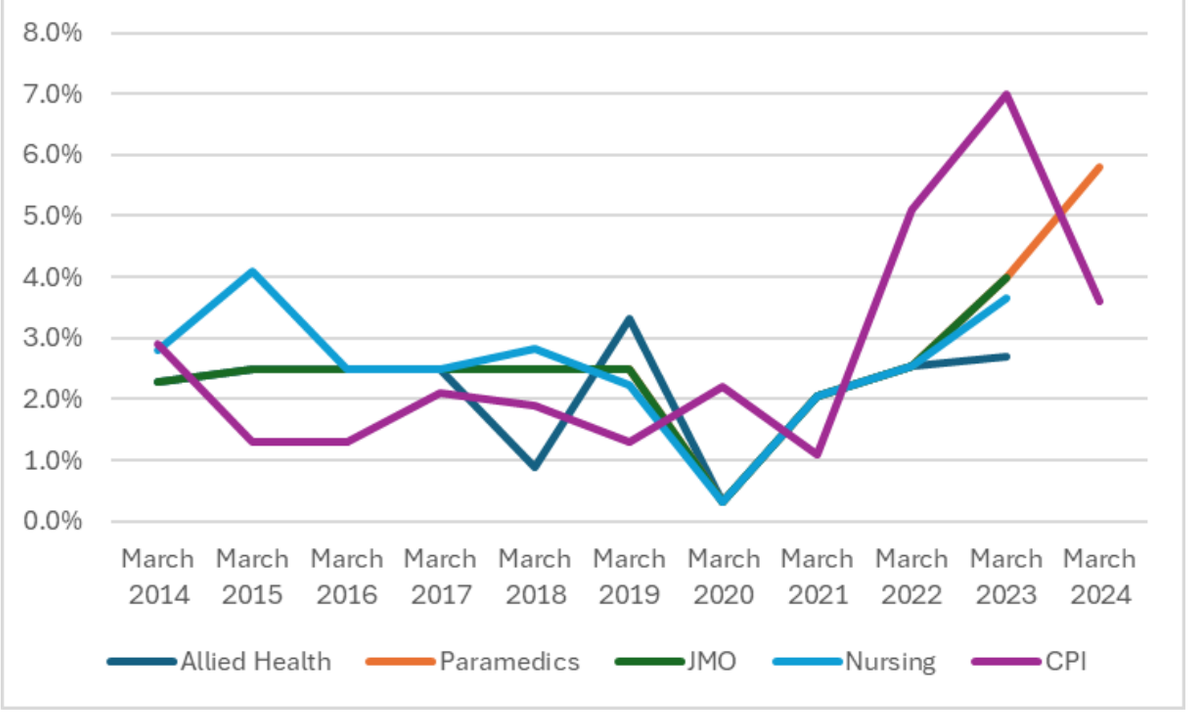
29. MOH tracks rates of pay by profession, including examination of actual earnings by profession and as against inflation.

30. Interstate comparisons are only made on available information on base salary. The base salary range for **Staff Specialists** in NSW is the lowest of all states and territories, **Junior Medical Officers (JMOs)** in NSW start on the lowest commencing salary but the top of the NSW band falls within the middle of the salaries offered by other states. **Registered Nurses (RNs) and Midwives** commencing salary is the second lowest of all states, but the top of the band falls within the middle of the salaries offered by other states. **Allied Health Professionals** commencing salary is within the middle of the range of other states, and the top of the band similarly falls within the middle of the range of salary offered by other states. It is to be noted that this base rate of pay does not reflect the different award conditions and does not account for any difference in

allowances and penalty rates which can significantly alter the actual rates of pay employees receive.

31. NSW does not have access to the average take home pay of employees in other jurisdictions. The average annual actual take home pay of a 1FTE employee for each profession is included in the *NSW Health Workforce Data Report*. This begins to highlight the impact of the different conditions on an employee's take home pay vs the base rate. For example, the minimum base pay for an RN in NSW is $70,050, however the average pay of a Nurse in NSW is 180% more at $127,036. Similarly, the minimum base rate for an allied health professional is $70,944 however the actual average take home pay is again about 180% more than the minimum at $127,882.

32. The year-on-year increases in wages growth for selected professions of Allied Health, Nursing and Medical and presents this relative to the March Consumer Price Index (**CPI**) each year. For Nurses and JMOs relative to CPI, each group has broadly received increases above the rate of inflation each year until relatively recently in 2022 when inflation began to climb. The exception to this was in 2020, where there was a one off and more modest increase in wages.



Source: Corporate Analytics Data Warehouse extracts, CPI data from ABS

Note 1: Increase in base rates of pay year on year for the identified group of employees. Not all employee groups shown as chart serves to provide an indicative representation of pay changes to CPI. As a number of groups have the same year on year rate changes, the lines trend together and may not appear visible on the above chart.

Note 2: paramedic data prior to 2017 is unavailable and not depicted in the figure. Additionally that CPI is the annualised figure at March, and for simplicity we have aligned the annual wage increase to this same point and should be interpreted indicative of how wages have changed relative to CPI over time. 2024 increases are identified when known.

33. MOH relies on the NSW Government wide PMES to obtain data on intention to exit NSW Health and align this with actual exit rates to predict attrition trends and plan for future workforce needs. The PMES offers insights into the workforce which can be used to identify potential indicators of attrition, and low engagement before any loss of staff. The PMES measures intention to exit and timing of when an employee is considering exiting. The intention to exit is broadly lower than the actual exit rates observed, which was as low as 5.1% in 2020, peaking at 8.4% in 2022, before trending down to 7.3% as at May 2024. This information can be used to identify areas with potential for higher prospective turnover and for managers to take steps to address any underlying concerns.

34. MOH has created a number of different targeted incentive schemes which aim to address supply of the workforce in rural and remote areas, including by offering recruitment and retention incentives which immediately act to attract and retain the workforce in these areas.

35. The Rural Health Workforce Incentive Scheme is offered across 14 local health districts, specialty health networks and health organisations. As at June 2024, 2,776 health workers have been recruited using recruitment incentives and 10,566 health workers have been retained.

36. MOH tracks how much has been paid in incentives and the number and location of recipients. LHDs and specialty networks enter details of incentive packages offered into a SharePoint database that WPTD manages and maintains. This database is updated on an ongoing basis and is used for weekly and monthly reporting.

37. As at June 2024, 2,776 health workers have been recruited using recruitment incentives and 10,566 health workers have received retention payments. The table below provides a breakdown of the employees by LHD/SN who have received a recruitment or retention incentive payment:

Health organisation	Recruitment	Retention
Far West	194	353
Hunter New England	713	3,801
Illawarra Shoalhaven	26	78
Justice Health Forensic Mental Health	82	219
Murrumbidgee	164	978
Mid North Coast	257	976
Nepean Blue Mountains	3	153
Northern NSW	449	1,589
South Eastern Sydney (Lord Howe)	-	5
Southern NSW	173	410
South Western Sydney	-	39
Western NSW	292	860
NSW Ambulance	152	364
NSW Health Pathology	271	741
Total	**2,776**	**10,566**

Source: Corporate Data Warehouse extracts

38. The Rural Health Scholarships boost the pipeline of health professionals to work in rural areas of the state. In 2022-23 a total of 232 scholarships were awarded valued at $677,000 covering a number of allied health, nursing and medical pathways.

39. MOH tracks how much has been paid in Rural Health Scholarships and Tertiary Health Study Subsidies. Scholarships are managed by the Health Education and Training Institute (**HETI**) on behalf of MOH, and reported to MOH WPTD monthly or on request.

40. The Tertiary Health Study Subsidy Program (**THSSP**) is a newer program and invests $97m over five years to attract and retain talent in the NSW public health system. The subsidy model develops and grows the health workforce pipeline across the state, by focusing on workforce and areas of need. Tertiary health subsidies are managed by HETI on behalf of MOH and monitored by the MOH by weekly report to WPTD. The WPTD

team report progress on Tertiary Heath Study Subsidies on a weekly basis to me, and to Jacqui Cross, Chief Nursing and Midwifery Officer. The Minister for Health's office regularly seeks updates on progress of awarding subsidies as it was a key election commitment in 2023.

41. Data on workforce metrics as outlined in paragraphs 10 through 28 are used to observe and monitor workforce trends against targeted or expected performance, and to monitor implementation success of strategies to address workforce need. Longer term workforce modelling across the various disciplines and specialties is undertaken using a combination of this data and a range of available national and international data to create a more fulsome understanding of future workforce supply.

Health Workforce Modelling

42. Analysing, forecasting, and managing the health workforce supply is complex due to the number of stakeholders involved and the number of internal and external variables that influence workforce supply and demand.

43. The NSW Health system undertakes workforce and service planning/forecasting that considers the following supply and demand factors:

    a. Supply factors: changing workforce expectations, Global supply, Federal reforms including NDIS, Aged care, comparative rates of pay in other jurisdictions, private market/sector opportunities and graduate pipeline.

    b. Demand factors: community expectations, ageing population, increasing health complexities, infrastructure redevelopment and population growth and mobility.

44. Health workforce modelling is undertaken by both MOH and the Commonwealth Department of Health and Aged Care. NSW Health's workforce modelling maps the current and forecast labour pool for a profession or specialty against projected health service workforce scenarios. The modelling utilises a stock and flow methodology with a projected workforce demand. The scope of modelling is utilising the registered

professions through Australian Health Professional Registration Authority (**AHPRA**) registration or by NSW Health payroll dataset.

45. Models are used to provide information to the health system on anticipated supply issues, and to highlight specialties and career opportunities looking over a decade into the future. This enables NSW Health to ensure our workforce has the capacity and capability to meet demand in the future. The modelling projections for medical, allied health and nursing workforce streams provide an indication of the number of required new graduates.

46. In 2021 NSW Health commenced updating of models for medical specialties, last completed in 2018. Modelling was undertaken for 35 medical specialities, and 22 allied health professions across NSW. In 2024 modelling of the nursing workforce was commenced. To date, modelling for RNs, Registered Midwives (**RMs**) and Enrolled Nurses (**ENs**) has been completed at Statewide level, and is now being undertaken at LHD level.

47. In NSW, the modelling indicates that the medical workforce requires an increase in graduates of between 165 to 212 per annum, and provides information for each speciality where there will be shortages in the training pipeline. This information is used by doctors when considering specialty training as it highlights the prospective career opportunities based on under or over supplied specialities. There are a range of medical specialties that have projected shortfalls in supply and consequently indicate substantial career opportunities for doctors choosing to train in that specialty. For example, Psychiatry modelling indicates that significant career opportunities exist, and the modelling suggests the workforce needs to grow by 14 – 16 new psychiatry fellows each year to meet demand. The Ministry of Health subsequently developed a Psychiatry workforce plan to address the emerging challenges associated with attracting doctors to psychiatry training.

48. Nursing modelling indicates that an increase of 'New to Practice' RNs is required at high demand scenario only and that RN numbers meet the current low demand. On the other hand, the modelling indicates that RM and EN numbers do not meet the high or low

demand, and increased numbers of 'New to Practice' RMs and ENs are required to address ongoing challenges with maldistribution between sectors (public and private), and geographic locations (metropolitan and rural).

49. Each allied health specialty has individual workforce drivers and characteristics that need to be considered and addressed. Similarly to nursing, attraction to NSW Health as an employer, maldistribution between sectors (public and private), and challenge associated with geographic locations (metropolitan and rural) are key factors that affect allied health professions. Allied Health professions that have been identified to be in significant demand include radiation therapy and sonography. NSW Health is working with key radiation therapy stakeholders, including universities, to look at solutions for resolution of this workforce issue. NSW Health has completed an internal scoping exercise for the Sonography workforce to understand the specific supply/training, demand drivers and retention challenges to understand current state to help inform future solutions.

50. MOH utilises this information obtained from modelling to facilitate discussions with stakeholders, such as training providers, to review and potentially modify workforce supply future pipelines and to inform strategic workforce planning at a local and statewide level.

F. HEALTH WORKFORCE – DISTRIBUTION AND STRATEGIC PLANNING

Strategic health workforce planning

51. The *NSW Health Workforce Plan* (**HWP**) 2022-2032 (**SCI.0001.0043.0001**), released in June 2022, is a 10-year strategic state-wide workforce plan and the delivery framework for the implementation of *Future Health's* (**MOH.0001.0320.0001**) workforce-related strategies across the health system. To achieve the HWP's intent, actions will set out across three horizons for the short term/immediate three years, medium term/midway point and longer term. The current plan outlines the horizon one (2023-2025) actions. MOH will use data and insights from the Future Health Measurement Intelligence Council to inform the development of Horizon Two of the HWP.

52. The HPW sets MOH's workforce priorities for the State which, with the *HWP Supplementary Plan*, assists NSW Health agencies to adopt these priorities locally. Health Agencies are expected to develop workforce plans to operationalise the HWP strategic outcomes to their local settings. These workforce plans will be informed by local data sets, relevant for their cultural context.

53. During the creation of the HWP, the WPTD branch led broad system wide consultation across internal and external NSW Health stakeholders to identify system priorities for the next five to ten years. Consultation included: four roundtables with more than 120 representatives across NSW Health, in-depth interviews with key leaders from the NSW Health system and NSW Government and survey responses from managers and staff of the health system. These findings were summarised and themed in the *Health Professionals Workforce Plan Consultation Report* **(MOH.0010.0276.0001)**.

54. The findings highlighted key areas for reform which informed the development of the HWP. These findings included:

    a. Changing population health needs and emerging models of care require new ways of working across the health workforce.

    b. Community and consumer needs must inform and guide the way the health workforce plans and delivers services.

    c. Rapid technology advances change what is possible in health, and significant workforce development is required to harness those opportunities.

    d. Leadership capability and positive workplace culture must be prioritised to enable workforce success.

    e. New pathways to professional practice are needed to enable new and flexible roles and teams.

    f. Education and training needs to refocus around new and emerging skills and be delivered in a way that aligns with workforce needs and learning styles.

Workforce maldistribution

55. The NSW Health workforce, like jurisdictions across Australia and other international jurisdictions, is challenged by undersupply of workforce in certain geographic regions and specialties. In NSW, it is particularly challenging in remote locations in western areas of the state.

56. Evidence shows that people who live and train in rural areas are more likely to stay in those areas and work.

57. Workforce strategies that focus on relocation, particularly to regional, rural and outer metro areas are limited by:

    a. Demographics of NSW Health workforce including gender and stage of life.

    b. Relocation needs for families including partner employment and childcare/schools for children.

    c. Lack of suitable accommodation.

    d. Working in isolation.

    e. Perceived lack of available support, reduced career and training opportunities.

    f. Population decline in small rural towns and the associated impact on town infrastructure and services.

    g. Some actual or perceived onerous on-call requirements.

58. NSW Health implements a range of strategies to address supply and/or maldistribution challenges of its workforce including:

    a. Building the capacity of the current workforce by via developing targeted education and/or training programs.

    b. Regional workforce recruitment and retention incentivisation.

c. Growing the pipeline of future workforces via a range of Scholarships/ Cadetships funded and managed by NSW Health to help support and grow the pipeline of workforces with skill shortages at either State-wide or localised (maldistribution).

d. Implementation of domestic and overseas recruitment strategies.

e. NSW Health can support short term workforce skills shortages by enabling our workforce to work flexibly in terms of hours, skill set and/or location and can respond in an agile way during times of crisis. This was demonstrated during COVID-19 where the vaccination clinics were mobilised and during the bushfires where staff were re-deployed into other LHDs. To sustain this capability, the **Central Resource Unit (CRU)** was established in May 2023 to deliver centrally coordinated support through mobilisation of workforce to areas of need, particularly as the system recovered from the COVID-19 pandemic. The CRU has proven to be successful and has deployed workforce to areas that have struggled with ongoing workforce supply. The MOH is scaling the CRU to employ 400 FTE over the next 3 years to support an ongoing pipeline of deployable health professionals across the system.

f. Implementation of Medical Workforce programs to attract more doctors in rural locations where they are needed most including the NSW Rural General Practice Procedural Training Program and Rural Preferential Recruitment Program.

59. Specialty workforces and specialty training positions, particularly for medical specialties, are quite metropolitan centric, for a range of reasons, including demand and activity limiting specialised procedures to metropolitan tertiary centres, and limitations of supervision. NSW Health continues to work with stakeholders to encourage training in regional and rural locations.

60. Forecasted injections of new graduate workforces will require statewide clinical supervision to support transition to practice. An example of this occurred in 2023 when the health system invested in a record number of new graduate nurses to offset attrition

across the state. Over 3500 new graduates commenced their nursing career in the NSW Health system. To support the nursing workforce with a larger number of new to practice nurses, the MOH funded an additional 100 Clinical Nurse Educators which were deployed across the state.

G. CONTINGENT LABOUR WORKFORCE

61. NSW Health's contingent workforce is primarily medical locums and agency nurses/midwives. Allied Health do not utilise large numbers of agency or locum staff.

62. The use of contingent workforce is an important feature of the health system, assisting it to remain agile and to scale up and down when needed.

63. Medical locums and agency nurses/midwives play an important role in the provision of health services to the community. They assist the NSW Health system cover short term and hard to fill vacancies, particularly in regional and rural areas affected by workforce maldistribution.

Medical Locums

64. Although a premium labour cost, medical locum staff only make up around **1.5%** of the total payroll costs for NSW Health and **0.4%** of the total FTE workforce.

65. The NSW Health policy directive PD2019_006 *Employment and Management of Locum Medical Officers by Public Health Organisations* (**MOH.0011.0005.0001**) requires all non-specialist medical locums to be sourced from qualified recruitment agencies on the NSW Health Register of Locum Medical Agencies. They are also subject to pre-placement and evidentiary documentation requirements and certification audits.

66. In recent years the demand for medical locums has been outstripping supply, not just in NSW, but across Australia. There are several factors contributing to this, including the disruption on supply and demand flowing from the COVID-19 pandemic and the attraction of high locum rates and flexible work arrangements to doctors. Given this, Health Ministers are currently exploring the potential for a national approach to improve locum management.

67. In addition, NSW Health is rolling out the state-wide implementation of a medical locums vendor management system, which improves locum agency performance management, and reduces agency commissions and administrative burdens on medical workforce units. LHDs who have implemented the new system have already seen a reduction in agency commissions.

68. NSW Health is scoping the viability of establishing an internally managed locum agency, which would engage and deploy locums to shifts across the state. The project will require thorough market analyses and legal advice regarding how an internal agency would be able to operate in the market without offending competition law. The challenge for an internal agency would be the need to match shift prices paid by other agencies in order to incentivise doctors to sign up with the internal agency.

69. It is impractical to expect that 100% of locums could ever be provided by one internal agency in NSW given the market is nationwide and locum agencies will continue to service other states.

70. Locum doctors are paid through the NSW Health payroll system.

71. Specialist medical locums are engaged separately by health agencies and paid as VMOs.

Agency Nurses/Midwives

72. Agency nurses and midwives are engaged directly by LHDs, SHNs and statewide services. Contracts with agencies are generally managed at the local individual LHD level or across a group of LHDs. The contracts require agency nurses to be remunerated at award rates and paid through the NSW Health payroll. This arrangement was initiated through a directive from the Department of Health in 2005.

73. The COVID-19 pandemic challenged NSW Health services with workforce surge requirements, and large-scale vaccination of the population, resulting in an increased reliance on the use of contingent nursing workforce.

74. Additional nursing workforce suppliers were sought to increase supply capacity, which necessitated some off payroll arrangements. These arrangements generally

remunerated the nursing workforce on the agency books at rates much higher than the NSW Health award rates. Costs increased significantly for LHDs that relied upon these services, in particular for Northern NSW and Western NSW LHDs.

75. NSW Health contingent labour review commissioned by the MOH and HealthShare NSW, recommended a statewide panel arrangement for nurses and midwives. The Whole of Health Nursing Agency Panel initiative (**MOH.0010.0281.0001**) was approved as an activity out of the Savings Leadership Program.

76. The objective of the Whole of Health Nursing Agency Panel is to establish a state-wide panel arrangement through open market approach for nurse agencies with a fixed / capped fee arrangement that considers factors like LHD location, supply and demand. This will enable a statewide consistent approach to engage suppliers of agency nurses and state-wide rate card to reduce risk of LHD competition.

77. A performance management framework, incorporating improved data reporting and Service Agreements between LHDs and agencies on the panel is being developed as an outcome of the project.

78. Contract implementation will be system-wide and will bind all LHDs, SHNs and statewide services. Upon execution, which is anticipated to be September 2024, the contract is expected to deliver projected savings of between $8.5m and $15.8m per year.

79. To reduce the reliance on contingent workforce for short term staffing needs, particularly in regional and rural locations, NSW Health has also implemented the NSW Health Deployment Program. As part of the program a CRU provides nurses, midwives and allied health professionals with opportunities to travel and work at hospitals and health services that have a short-term need for their skills and experience. Deployments are between two and thirteen weeks. This pipeline of deployable health professionals will deliver the equivalent of 400 FTE to system by FY27.

H. ATTRACTION AND RETENTION

79. The ability to attract and retain the NSW Health workforce varies across geographic regions and also some specialties. LHDs experience difficulty attracting health workers from a number of health disciplines to some hard to fill rural and remote locations in NSW.

80. External market factors, including the NDIS, Aged Care and the private sector continue to place pressures on our workforce with a combination of financial and non-financial drivers.

81. COVID-19 disrupted the NSW Health workforce including changing trends with recruitment and retention, public perception health careers and changing workforce expectations.

82. During the COVID-19 pandemic, the NSW Health system saw an increase in its permanent retention rate to 94 in 2020-21 as staff remained in the system to assist with the pandemic response. Following the Delta wave and during the lead up to OMICRON, the retention rate declined, particularly in regional, rural and remote areas. The retention rate for regional areas at that time was 90.7% at June 2022, and was 92.4% at June 2022 for metropolitan areas.

83. As a result, the NSW Health system focused on attraction and retention strategies for the NSW Health workforce, including incentives for regional hard to fill locations. The permanent retention rate has steadily increased and is now at 92.8% as at June 2024 for all of NSW Health.

84. A reversal of the declining retention trend has occurred in response to the introduction of the Rural Health Workforce Incentive Scheme, with permanent employee retention rates in rural LHDs increasing by 1.4% since June 2022 to 92.1% as at June 2024.

85. NSW Health has a range of financial incentives to facilitate recruitment and retention of the current or future health workforce within NSW Health. I address these next.

Recruitment and Retention Incentives

86. The **Rural Health Workforce Incentive Scheme** was introduced in July 2022 and enables participating NSW Health organisations to offer incentives and benefits above award entitlements to attract, recruit, and retain health workers in positions with hard-to-fill and critical vacancies at regional, rural, and remote locations. Eligible locations include those categorised as MM3-MM7 using the Australian government's Modified Monash Model of rurality, as well as Tweed Heads, Murwillumbah, and Queanbeyan. As at 26 June 2024 the program has paid more than $75m in incentives to recruit and retain talent in the NSW Health System: $20m in recruitment incentives and $55m in retention incentives. The scheme provides for a range of scaled incentives of up to $20,000 for the first year inclusive of a sign on bonus for the most difficult to fill areas, with retention payments in subsequent years of up to $10,000. Staff already in place at the time a role is classified as hard to fill receive retention packages on an ongoing basis. As at June 2024, 2776 NSW Health employees have been recruited under the scheme since its inception.

87. There are incentives to support students studying health related courses include subsides, scholarships and grants. Some of these are profession specific while others can be broadly applied across professions:

    a. **Tertiary Health Study Subsidies,** which are designed to target university students by supporting new entrants to health careers. The subsidies are available to fifteen health workforce groups targeting newly enrolled students in nominated health degrees or courses or current students due to graduate and who start work with NSW Health. NSW Health offers two subsidies under the program:

        i. $12,000 subsidy paid over three years to students commencing study in 2024, 2025 or 2026, who commit to work for NSW Health upon completion of their studies for a minimum of 5 years.

        ii. $8,000 subsidy paid on a one-off basis to students graduating study and commencing employment with NSW Health in a profession

resulting from their study in 2024, 2025, and 2026 and who commit to stay with NSW Health for a minimum of 5 years.

b. **Rural Undergraduate Scholarships** are available for undergraduate nursing and midwifery students living in rural NSW. In their first year of study, students are eligible to receive $5,000.

c. **Nursing and Midwifery Undergraduate Clinical Placement Grants** up to $1,000 are available to support nursing and midwifery students attending clinical placements. Students are eligible if the placement is in a NSW public health facility over 150km from the student's university.

d. **NSW Health Aboriginal Nursing and Midwifery Undergraduate Scholarships** of up to $1,000 per subject are available for Aboriginal and/or Torres Strait Islander students undertaking a Bachelor of Nursing or Bachelor of Midwifery.

e. **NSW Health Aboriginal Enrolled Nurse to RN Scholarships** of up to $15,000 per year are available to Aboriginal and/or Torres Strait Islander students who hold a Diploma of Nursing qualification and are undertaking a Bachelor of Nursing.

f. **Diploma of Nursing Rural Travel Support Incentive** for associated travel and accommodation costs related to Diploma of Nursing studies. Diploma of Nursing students residing in regional or rural areas (MM3-MM7) are eligible to receive $5,000.

g. **Nursing and Midwifery Post Graduate Scholarships** support career progression and retention of a skilled workforce. Scholarships of up to $10,000 are awarded to NSW Health nurses and midwives to support professional development in a range of areas including clinical nursing, education, management and nurse practitioner.

h. **Rural postgraduate midwifery student scholarships** are provided as a "Grow Your Own" strategy for midwifery. These scholarships are allocated to small rural maternity units, to support the employment of a midwifery student, in addition to their existing full-time equivalent establishment profile. The scholarships support the sustainability of small rural maternity units by funding a local RN to train as a midwife. 20 rural postgraduate midwifery student scholarships were funded in 2023.

i. **Rural Allied Health Undergraduate Scholarships**: Students from rural backgrounds undertaking 'entry level' studies in allied health leading to a degree qualifying the student to practice can apply for undergraduate scholarships of up to $10,000.

j. **Rural Allied Health Clinical Placement Grants**: Rural and urban allied health students can apply for grants of up $1,000 to subsidise travel and accommodation costs associated with rural clinical placements. The aim is to provide students with an experience of working in rural to encourage them to return work in rural locations.

k. **Aboriginal Rural Allied Health University Student Scholarship** provides $10,000 financial assistance to Aboriginal allied health students with a rural background residing in regional or rural areas (MM3-MM7).

l. **Rural Allied Health Assistant Scholarship** provides financial assistance for individuals from a rural area (MM3-MM7) to complete an Allied Health Assistant qualification at TAFE NSW up to $3000.

m. **Supporting Entry into University Medicine or Dentistry Program Scholarship** provide financial support to prospective students from NSW rural communities (MM3-MM7) who are pursuing a career in medicine or dentistry up to $1200 to sit the Graduate Medical School Admissions Test (**GAMSAT**) or University Clinical Aptitude Test (**UCAT**).

n. **Getting Started in Medicine Scholarship** for First Year Students provides support to students pursuing a career in medicine from NSW rural communities to assist with relocation and support study commencement costs up to $1500.

o. **NSW Rural Resident Medical Officer Cadetship Program** offers NSW medical students interested in undertaking a career in rural NSW. The Cadetship Program provides financial support of up to $15,000 per year to medical students during their final two or three years of undergraduate study in return for the completion of two of their first three postgraduate years in a rural hospital. NSW Health currently supports 48 Cadetships, which are administered by the Rural Doctors Network for medical students in regional hospitals across NSW.

88. To encourage doctors to specialise in Psychiatry, HETI dropped its fee for the Post Graduate Psychiatry training course from $5,940 to $1,000 in 2020.

89. Financial subsidies are available for current NSW Health professionals to support ongoing professional development:

    a. **NSW Rural Allied Health Postgraduate Scholarships**: Health clinicians in rural public health services are invited to apply for scholarships of up to $10,000 to assist with expenses directly associated with postgraduate study.

    b. **Rural Allied Health Generalist Program (Level 1) Scholarships**: The Allied Health Rural Generalist Program (Level 1) Scholarship provides financial assistance of up to $12,000 to complete the Level 1 Allied Health Rural Generalist Program through James Cook University. Scholarship funds can be used for course fees, technology or other costs associated with completing this training program.

    c. **Allied Health Rural Graduate Diploma of Rural Generalist Practice (Level 2) Scholarships**: Provides financial assistance ($35,000) for NSW Health allied health professionals currently working in a rural area to complete the Graduate Diploma of Rural Generalist Practice through James Cook University

    d. **The NSW Rural Generalist Training Program** is a statewide program aimed at producing doctors who are General Practitioners with advanced skills able to deliver services to rural communities. 58 training positions are available in 2024 across NSW. There will be 62 positions in 2025 and a total of 66 positions in 2026. Rural Generalist Scholarships to the value of $3,000 are being offered to each Rural Generalist trainee who starts advanced skills training.

Role of NSW in General Practitioner Training

90. The Australian Government is responsible for General Practice (**GP**) training policy and funding. It funds GP training through the Australian General Practice Training Program with 1500 Government training places each year.

91. The two accredited medical colleges responsible for GP training are the Royal Australian College of General Practitioners and the Australian College of Rural and Remote

Medicine. They are responsible for selection into training, with direct responsibility for the training curriculum and assessment, clinical placements, accreditation of training sites, and the work of medical educators to supplement the training provided by supervisors in a practice.

92. The NSW Government has partnered with the Australian Government to support primary care workforce reform, including developing new models in rural and remote areas such as the Single Employer Model for Rural Generalists.

93. **The Single Employer Model** allows LHDs to employ rural generalist trainees to work in local hospitals and general practices while completing their rural generalist training. This model helps attract doctors to work in regional, rural and remote NSW, while completing their rural generalist training, by providing a guaranteed minimum salary and employment benefits.

94. In addition to the **NSW Rural Generalist Training Program**, the NSW government also funds the **NSW Rural General Practice Procedural Training Program** which provides opportunities for rural general practitioners to acquire additional procedural skills such as anaesthetics or obstetrics. There are 20 positions available each year. Since 2023, these positions are now paid at the equivalent of Level 1 Staff Specialist as an incentive to attract general practitioners.

95. **John Flynn Prevocational Doctors Program (JFPDP)** is funded by the Commonwealth and provides junior doctors an opportunity to complete a 10-week training rotation in regional General Practice. In NSW, this is managed by the prevocational training networks.

96. All other GP trainees are funded by the Australian government. The Medical Board of Australia governs and approves the curriculum and accreditation of GP training via the Australian Medical Council (**AMC**). The AMC accredits the two GP colleges to provide the appropriate training. These trainees undertake all their training in the private sector. Other than Rural Generalists who partially train and work in NSW public health facilities, NSW has no role to play in any other aspect of GP training.

Health workforce culture and engagement

97. NSW Health commenced a program of surveying the workforce in 2011 to measure employee engagement and culture. The Your Say Survey, which was unique to the NSW Health system, ran in 2011, 2013 and 2015. The survey was distributed across the health sector and the results captured the views of the entire health workforce for the first time.

98. The PMES initially rolled out in 2016 as government wide annual survey across the public sector workforce. Other than 2020 during the pandemic, NSW Health has participated every year.

99. NSW Health negotiated with the Public Service Commission at the conclusion of the Your Say Survey contract to continue to provide the health system with culture index scores through the new PMES, which is an index that is unique to the health system and not reported across other government departments.

100. Response rates have increased for NSW Health overall from 46% in 2022 to 47% in 2023. In 2023, a total of 81,815 staff responded, the largest number of Health staff to have ever completed the survey. The response rate of 47% is the highest since 2019 and the second-highest since NSW Health began participating in the survey.

101. The engagement and culture scores for all NSW Health organisations over the history of the PMES is outlined in the table below.

Key Topic Area	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Engagement Index	63%	-	67%	-	68%	65%	64%	65%	65%	No Survey	64%	62%	63%
Culture Index	46%	-	52%	-	54%	57%	58%	60%	60%		58%	59%	61%
Response Rate	25%	-	32%	-	41%	27%	36%	46%	49%		32%	46%	47%
Total responses	31,493	-	43,324	-	42,660	38,927	48,839	65,677	72,279		52,564	76,187	81,815

102. The NSW Health system has seen a general improvement in culture scores since 2012 to 2023. Engagement has remained relatively stable at 63% for both 2011 and 2023. During this period the engagement index has ranged from 62%-67%. Culture has improved by 15% points from 46% in 2012 to 61% in 2023. The Culture index in 2023 was the highest results since its inception.

103. The MOH releases $4.6m annually from the WPTD to 22 NSW Health organisations with an annual proportional allocation to fund culture initiatives to address the findings of the PMES. NSW Health organisations are required to submit a Culture and Safety Action Plan to MOH as a requirement for the funding.

104. The most common initiatives in the Culture and Safety Action plans relate to leadership development programs, conflict management, communication, diversity and inclusion, psychosocial risk management, bullying, violence prevention and talent management.

105. The table below provides a summary of the most common initiatives listed in the PMES Culture and Safety Action Plans, mapped to the PMES themes and key topic areas.

Table: Summary of Key Culture and Safety Action Plan Initiatives mapped to PMES Key Topics.

	PMES Theme	Key Culture and Safety Action Plan Initiatives
Leadership	Senior Managers and People Leaders	• Leadership development programs • Capability uplift programs • Leader accessibility
	Communication & Change Management	• Regular, clear communication • Conflict management • Change management capability
	Employee Voice	• PMES Action Planning • Staff Networks • PMES analysis • Exit survey improvement
Work Environment	Diversity and Inclusion	• Diversity and Inclusion staff networks, awareness training, events. • Disability Confident recruiter training and Public Service Commission (PSC) Inclusion toolkit • Aboriginal workforce planning and cultural safety
	Health and Safety	• Violence and aggression prevention • Psychosocial risk management • Bullying prevention • Fatigue management • Safe complaints pathways • Peer support • Healthy eating and lifestyle education

	Grievance Handling	• Grievance procedures focused on improving notification, recording and response
	Flexible Working	• Trial of 12- hour shifts for clinical staff • Developing flexible work practice frameworks and work from home initiatives
	Learning and Development	• Talent management framework design, including career pathways and succession planning
	Recognition	• Development of recognition frameworks • Formal award events
Purpose and Direction	Ethics and Values	• Embedding CORE values into ways of working and communication

106. The WPTD branch is currently developing the *NSW Health Culture and Staff Experience Framework* (**MOH.0010.0278.0001**) and a *Framework in Practice* (**MOH.0010.0277.0001**), which set out NSW Health's core values, the levers to achieve these and identifies what success looks like in striving for a positive culture. This will be supported by a Culture and Staff Experience Portal. The Culture and Staff Experience Portal will host resources for all NSW Health organisations and affiliated health organisations to access and utilise. Resources will include leading practice research, shared examples of good culture and wellbeing practices in the health system, multimedia resources for use in system promotions, discussion forums, and archived materials on showcased events that demonstrate the organisations commitment to positive culture development and investment.

I. GOVERNANCE AND STRUCTURE OF EDUCATION AND TRAINING IN NSW HEALTH

107. The education and training ecosystem is complex with numerous key stakeholder groups, both internal and external to NSW Health. Training and education is provided by a mix of providers, including LHDs, HETI, MOH and registered training organisations including universities and TAFE NSW. NSW Health is a significant provider of training and education.

108. Education for health careers relates to the provision of theoretical knowledge, intellectual, conceptual and ethical foundations to prepare students for a career in the health sector. Universities and other education providers are primarily responsible for the provision of education pre-employment, at a vocational training or undergraduate level.

109. Training is the development of skills and specialist knowledge to prepare health workers for particular vocational specialities and jobs in the health sector.

110. Education and training in the health system is multi-faceted, occurs at all levels of the workforce, and is delivered in a range of settings including virtual delivery. Both training and education continues across the career continuum of both clinical and non-clinical workforces in the following ways:

    a. **Universities** provide the primary pathway for undergraduate programs for health professionals, with close relationships with the NSW Health system to facilitate clinical placement experiences to observe the application of education in the health setting.

    b. **Medical Colleges** – the AMC accredits colleges to provide specialist medical training in NSW. The Medical Colleges determine specialist medical training program curriculum and training requirements. The 16 Medical Colleges are independent member organisations with Trainees and College Fellows paying annual membership fees. Medical Colleges have differing processes for selecting doctors to participate in their programs. Some colleges have almost complete control over selection, while others will have little involvement. Medical Colleges also assess and accredit hospital units to deliver specialty medical education and will take into account a number of factors such as level of available supervision, activity and learning outcomes prior to accrediting the site for training.

    c. **HETI** provides a range of education and training programs across the NSW Health system, including postgraduate higher education programs, nationally recognised and accredited courses, a large selection of workplace and personal skills development programs, as well as provision of mandatory training modules for all health staff. HETI manages the state learning management system, known as My

Health Learning, in conjunction with eHealth NSW, which provides a portal for all NSW Health staff to access courses, modules and mandatory training. HETI also manages a range of scholarships on behalf of MOH.

d. HETI works collaboratively with NSW Health organisations to deliver programs of identified and agreed state priority through its District HETI division. A standing annual funding arrangement was established in 2012 for each LHD and SHN to contribute to resourcing via either actual staff contribution or equivalent funding to provide capacity to develop resources for health system wide priorities and utilisation. MOH will from time to time assist with facilitating contributions from organisations who do not provide payment in line with the arrangement.

e. MOH manages the performance of HETI in line with the health system performance management structure set by the System Performance and Sustainability Division and has an annual review process to discuss achievements and progress against its service agreement, and any issues that may be impacting performance.

f. Relationships also exist with a range of **vocational education** providers such as TAFE NSW, for vocational clinical, assistant workforce and support workforce pipelines, such as Assistants in Nursing, ENs, Allied Health Assistants, Aboriginal Health Practitioners, cleaning staff, and other health services assistants.

g. **LHDs** have, as part of their functions under the *Health Services Act 1997,* an expectation to provide training and education relevant to the provision of health services. This includes facilitation of student placements in the health system, provision of in-role clinical skills training, professional practice advancement, and education and ongoing development in a range of clinical and non-clinical areas.

h. Other organisations provide education and training services on a contractual basis for ongoing skills and personal development, such as LinkedIn Learning for short course leadership and personal development programs.

111. The majority of health professionals begin their educational pathway at university with a combination of theoretical scientific/clinical knowledge and practical clinical placements.

Clinical placements are provided by a range of providers, including NSW Health. Training and obtainment of qualifications, particularly for medical and some allied health graduates, continues while they are NSW Health employees.

112. There are important differences in training and education in terms of funding and structure between medical, nursing and allied health disciplines:

a. **Medical**: on average it is 10 to 20 years from the time a doctor enters medical school to becoming a qualified medical specialist.

i. Medical School: Doctors are required to complete a degree (either undergraduate or postgraduate) from a University medical school accredited by the AMC.

ii. Prevocational Training: The first two postgraduate years, including the first year which is internship. Internship requirements are determined by the Medical Board of Australia and must be completed to obtain general registration and be eligible to progress to specialist training.

iii. Specialist (Vocational) Training: Specialist (vocational) training programs are on average 3 to 6 years in length. Medical practitioners must complete an AMC accredited medical specialist training program to become a specialist in Australia and be eligible for specialist registration and eligible for a Medicare provider number. Training must be completed in a medical college accredited training site.

b. **Nursing and midwifery**: RNs have completed an accredited tertiary nursing degree, while ENs have completed a Nursing Diploma, provided by accredited Vocational Education Training providers. Midwifery has two different education pathways via either a Bachelor of Midwifery (B. Mid) or Graduate Diploma (post B. Nursing). Masters qualified Midwives are eligible to practice as both a RN and RM pending registration with the relevant board. Nurses and midwives start with generalist skills and may choose to specialise in a particular field although this is not mandatory. The Nurse Practitioner grading is an endorsement in addition to a RN and requires a specific study pathway to become qualified. This can be in a generalist or specialist area.

c. **Allied health professionals** are tertiary qualified health professionals who hold relevant State or Territory registration, licence or accreditation to practice. Allied health professionals must obtain a degree from an accredited educational institution relevant to their field. Within NSW Health there are 23 recognised Allied Health professions each with different training pathways including both undergraduate and postgraduate qualifications that combine both clinical placements and theoretical learning. On graduation, students are typically qualified to practice. There is a small number of professionals that require an additional 'internship' or 'registrar' year(s) – often referred to as 'supervised years of practice'.

d. **Aboriginal Health Practitioners** are AHPRA registered professionals and provide direct clinical services to local Aboriginal communities. Aboriginal Health Practitioners are required to hold a Certificate IV Aboriginal and/or Torres Strait Islander Primary Health Care Practice and be registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia. Aboriginal Health Practitioners perform a range of clinical practice and primary healthcare duties. Aboriginal Health Practitioners have a different pay scale to Aboriginal Health Workers. The training is completion of a Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care Practice. 19 units consisting of 14 core units and 5 elective units must be completed. Students are also required to complete 500 hours work placement in their workplace.

113. A range of non-clinical training is provided across the state from a variety of providers. HETI delivers a large range of management, leadership and personal development courses open to all staff in the health system. The courses offered by HETI are a mix of full on-line delivery, blended on-line and face to face, and some full face to face delivery.

114. Leadership and management training includes emerging/potential leader programs, middle and senior leadership programs, facilitation skills programs, short courses aimed at areas of management and leadership skills development, and leadership in specialised areas, such as clinical and quality, finance, medical management, people and culture, and behaviour management.

115. Some programs are commissioned directly by MOH to address identified areas of priority or focus, such as the Financial Management Essentials Program to develop financial capabilities in leaders in the health system, the People Management Skills Program, and the Next Generation of Leaders and Managers Program, which were programs aimed at identifying future leaders from staff and developing people leadership skills. These programs were funded by MOH and allocated funds to HETI through the WPTD Branch. The WPTD Branch then worked closely with HETI to oversee governance of the programs and ensure that the programs are evaluated and deemed effective.

116. LHDs and SHNs have learning and development departments that offer courses open to staff within their organisation, including leadership and management programs, communication, local culture development programs and security and safety training. The devolved nature and the scale of the NSW Health system means there are some variations and duplications of some programs across the state.

117. A number of health organisations also have access to LinkedIn Learning, which caters for virtual on-line delivery of personal development courses, as well as some information technology short courses.

118. There are a large range of computer software training programs offered to NSW Health staff through Microsoft learn, which is targeted at short course skill development in computer software packages.

119. Some courses are offered by the pillar organisations, mostly co-developed with HETI but with the subject matter expertise of staff within the pillars. For example, the Clinical Excellence Commission (**CEC**) offers courses in quality and safety through its CEC Academy. HETI staff provide the learning development expertise in the course design, which is then delivered through the Academy. A digital academy has also been developed with eHealth and HETI to offer short skills development courses in computing and digital health. These programs are accessible through My Health Learning, the learning management system.

120. Some nursing leadership programs are also coordinated through the Nursing and Midwifery Office at MOH.

Mandatory Training

121. Mandatory training is defined as training and / or education in a defined subject matter that must be undertaken by specified staff of a NSW Health entity. The basis for the requirement of mandated training arises from either legislation, or National Safety and Quality Health Service Standards (**NSQHSS**), or an organisational requirement based on emerging priorities. Training can be mandated for all staff, or a section of the workforce.

122. Mandatory Training governance sits under the purview of the Deputy Secretary, People, Culture and Governance.

123. MOH governs what programs are considered mandatory training for staff in the NSW Health system through the Mandatory Training Standing Committee (**MTSC**), which I chair. The MTSC reports through to the Deputy Secretary. The Mandatory Training Operational Advisory Group (**MTOAG**) reports through to the MTSC.

124. WPTD regularly review and address any system issues with the Mandatory Training policy, including workforce experience and ICT operational issues impacting on the workforce experience.

125. The MTSC is the peak approval body for mandatory training, providing oversight of the governance and standards for mandatory training in NSW Health. The MTSC Terms of Reference state the committee is responsible for applying the policy *PD2016_048: Mandatory Training Requirements in Policy Directives* (**MOH.0010.0261.0001**) and for prioritisation and coordination of "a simplified approach for sustaining Mandatory Training".

126. The MTSC assesses submissions from various sections and organisations from within NSW Health, usually requested by state policy authors in the MOH or Pillar organisations, against set criteria, including cost effectiveness, and endorses or declines based on organisational interest. If endorsed, the appropriate area, usually HETI, will take carriage of development and delivery of the relevant mandatory training module in conjunction with the policy owner and the relevant subject matter experts. The general approach of the MTSC in relation to assessment of submissions is to ensure all elements

of the mandatory training policy are satisfied, that mandatory training is delivered in the most time effective way to ensure as little impost on clinician time and as little diversion from productivity as possible, and that there are no alternate ways of delivering the appropriate information to staff that would meet organisational requirements.

127. The MTOAG provides expert advice to the MTSC and is responsible for prioritising and addressing the operational issues associated with the implementation of mandatory training requirements. MTOAG has a responsibility to provide advice to MTSC regarding operationalisation of mandatory training across NSW Health.

128. While these governance arrangements manage the regular review and applications for new mandatory training requests through the application of the policy document, there are also regular reviews and initiatives to address ongoing concerns with the ITC infrastructure behind mandatory training, the communication of critical decisions, and the impact of mandatory training on the workforce and workplace.

129. MOH regularly seeks information in relation to the current impost of training time on various groups across the health system to ensure that training is effective and not unduly impacting cohorts of the workforce. There have been a number of projects undertaken from time to time to explore best practice learning theory to ensure our delivery methods are contemporary and effective.

130. Two examples of mandatory training reform projects that MOH has invested in include:

    a. **Behavioural Insights Project (2017)** –

        i. Through the application of behavioural insights theory, the project focused on redesign of mandatory training modules with a refreshed perspective for nurses and midwives.

        ii. The project developed several new modules involving innovative and new technology such as Virtual Reality, Qstream and Parallax scrolling.

        iii. All modules were finalised and approved by November 2019 with the launch of the new modules in My Health Learning in February 2020 in line with the intake of new graduate nurses.

iv. Outcomes from the project demonstrated that the new educational resources were quicker to complete, more meaningful and recognised the everyday work practices of NSW Health Nurses and Midwives. A total of 15 Mandatory Training modules have been consolidated into 7 short educational resources for Nursing and Midwifery staff. The new resources have also led to a 70% time saving for Nursing and Midwifery staff completing their Mandatory Training for the first time - this equates to a saving of 4 to 7 hours per staff member.

b. **Process Improvement Project**: WPTD Branch invested in an external review of the governance arrangements for mandatory training, with a view to understanding:

i. Opportunities to streamline the operational aspects of mandatory training and defining/identifying staff to participate (targeting). Intending to reduce the experience of staff being unnecessarily targeted for mandatory training not associated with their roles.

ii. Opportunities to improve the quality of mandatory training proposals and support effective assessment, approval and feedback mechanisms to be in place intended to reduce the number of proposals for new mandatory training through better assessment of requests and their purpose. Outcomes from this review have been instrumental in influencing the advice and guidance being offered other MOH Branches and Pillars when proposing new mandatory training, and further work under the Time For Care Review and the review of Blue Flags in local health districts.

131. In 2024, there are a total of 110 red-flagged Mandatory Training courses. The number targeted to an individual employee or contractor varies based on their Australian and New Zealand Standard Classification of Occupations (**ANZSCO**) code, service, department and role. The summary of completions and time spent are in the table below. Please note:

a. Red-flagged mandatory training courses are those endorsed as mandatory at the state level by the Mandatory Training Standing Committee.

b. Blue-flagged mandatory training courses are those endorsed as mandatory at the local organisational level by the Chief Executive. Blue flagged courses are excluded from the table.

c. Most red flagged mandatory training is targeted according to an individual's ANZSCO code. Training can also be targeted based on other parameters like salary classification.

d. Red flagged mandatory training includes both state-wide mandatory training (where all individuals assigned that ANZSCO code are targeted) and locally determined mandatory training (where some individuals assigned that ANZSCO code are targeted, according to the service or department in which they work, or according to their specific role).

e. While there are 110 identified red flagged courses, some of these courses are grouped together as part of a Learning Pathway.

132. The summary of completions and time spent are in the table below.

	2022		**2023**		**2024 (Jan to 31 May) 2024**	
	Completions	**Time Spent (hr)**	**Completions**	**Time Spent (hr)**	**Completions**	**Time Spent (hr)**
TOTAL	459,184	264,201	763,287	386,070	528,523	239,907

133. The breakdown of completions and time spent (hrs) by Statewide Mandatory Training courses are at **(MOH.0010.0076.0001).**

134. **Learning Needs Assessment**. NSW Health completed a Learning Needs Assessment in 2023. This report was provided to HETI to review and consider for development of training and education priorities. HETI has now completed a gap analysis of their current

learning offerings against the identified needs. The recommended learning needs identified were:

Status	Learning Need Identified
Prioritised learning needs requiring system-wide action	Growth mindset for continuous learning in a changing health landscape.
	Maximising cognitive capacity to promote wellbeing and reduce burnout.
	Mitigating unconscious bias.
	Creating a climate of psychological safety for a positive, safe, and performing culture.
	Human-centred approach to work (communication, collaboration, and partnership).
	Digital readiness and technology adoption.
	Managing and leading change.
	Problem-solving for adapting to customized patient-centred care.
	Patient Safety and Quality and Staff Work, Health and Safety needs.
Prioritised learning needs currently being met but for which an enhancement is suggested	Staff Work, Health and Safety needs.
	Cultural capabilities. Continue to deepen both staff understanding and application of cultural capabilities as “the way we work”. The key is ensuring translation from learning to impact and specifically, behavioural changes at scale
	Digital capabilities.
	Workplace skills e.g. empathy, communication skills, problem solving, wellbeing and self-care.
Not systemwide, but priorities that require further targeting	Evaluation skills.
	Economics and health funding.
	AI and augmented reality.

Student placements:

135. NSW Health provides placements to students studying health-related qualifications, including medicine, nursing and midwifery, 23 allied health professions and other technical / scientific undergraduate programs with health care placement requirements.

136. NSW Health currently partners with 94 Australian education providers in the vocational education and training (**VET**) and higher education sectors from all states and territories to deliver placements.

137. Placements are governed by the *Student Placements in NSW Health* policy directive and the *NSW Health Student Placement Agreemen*t.

138. Each NSW Health organisation determines their capacity to provide student placements to education providers.

139. Placements are managed through ClinConnect, the NSW Health student placement booking system.

140. Student placement supervision models vary. Most students are supervised by NSW Health clinicians within NSW Health facilities. Students in non-clinical disciplines may attend placements remotely. Education providers support nursing students in metropolitan areas through an external facilitation model.

141. There are many NSW Health Organisations across NSW Health Involved in student placements.

    a. MOH (WPTD) as the policy owner of the *Student Placements in NSW Health* Policy Directive.

    b. Student placements are undertaken and governed at a local level between the LHD and education institution via their Student Placement Agreement and any other local agreements.

c. eHealth NSW provides system development, integration, administration, access control, hosting, technical support and control for the ClinConnect System.

d. HETI is responsible for

i. Student placement reporting.

ii. Requirements gathering for system enhancement from NSW Health organisations and education institutions.

iii. Administration support to organisations – for example, late placements or reinstating cancelled placements.

142. NSW Health also host clinical placements for university medical, allied health, nursing and midwifery students. VET sector placements include Aboriginal Health Practitioners, Allied Health Assistants and Enrolled Nurses.

143. NSW Health also provides an increasing number of non-clinical placements, for example in Public Health. To recognise the broadening of scope to include students in non-health disciplines who also undertake placements at the discretion of the Public Health Organisation *IB2021_025 NSW Health Student Placement Agreement* has transitioned its terminology from 'Clinical Placements' to 'Student Placements'.

144. NSW Health host over 11 million student hours of placements to both clinical and non-clinical placements for university and VET sector student as noted in the table below.

Health Service	Total Student Placement Hours by Health Service by calendar year		
	2022	2023	2024 (up to 31 May)
ACI	0	6,360	280
ASNSW	165,100	104,391	35,345
CCLHD	449,798	394,376	185,555
FWLHD	45,749	45,016	20,537
HNELHD	1,213,558	1,144,236	543,313

HS	13,670	11,132	2,120
ISLHD	515,280	451,952	168,949
JH&FMHN	109,124	100,494	40,801
MLHD	254,538	243,931	136,410
MNCLHD	319,619	337,475	142,101
NBMLHD	516,114	576,762	187,730
NNSWLHD	455,936	438,943	188,562
NSLHD	771,040	747,888	261,724
NSWPATH	27,448	37,831	17,728
SCHN	440,961	421,143	148,893
SESLHD	1,364,440	1,339,170	480,663
SLHD	1,232,011	1,148,482	422,036
SNSWLHD	178,177	184,897	73,642
SVHN	397,512	398,485	141,243
SWSLHD	1,684,903	1,628,385	652,932
WNSWLHD	351,595	351,961	167,920
WSLHD	1,290,070	1,251,908	499,551
Total	**11,798,665**	**11,367,241**	**4,518,035**

Source: ClinConnect

145. The distribution of student placements by discipline and Health Agency are exhibited to this statement **(MOH.0010.0273.0001).**

J. CHALLENGES

Workforce planning

146. It is challenging in NSW to build a full and accurate picture of workforce need against demand, and then to properly develop workforce strategies that address emerging workforce needs. Data availability, access, and governance challenges the ability of the WPTD to fully prepare for the dynamic environment within which NSW Health operates. For example:

a. The need for manual correlation of multiple data sets to fully understand workforce need, activity demand and safety and quality implications of workforce models,

b. Limitations on the use of important data sets arising from privacy legislation,

c. Limitations in comparative assessment against other jurisdictions,

d. Difficulty correlating activity and workforce data,

e. Limitations of a one size fits all PMES measuring tool that is designed to operate across a public service of over 400,000 employees, and

f. Challenges in measuring and collecting data on outcomes aligned to employee satisfaction.

147. NSW Health is a large and complex training and employment environment and operates with multiple stakeholder groups that are able to influence and exert control over pipelines of workforces that the system relies on to provide health services. Recruitment and retention challenges are also influenced by internal and external drivers. While NSW Health has made some significant improvements it is challenged by the varying degrees of influence that it has over external forces. Some examples of the challenges faced by the system in addressing training and workforce attraction and retention include:

a. Multiple sectors and jurisdictions are involved in the training lifecycle of medical workforce from university to specialist practitioner, with funding mechanisms controlled by different entities. It is not possible for NSW Health to control its medical workforce pipeline to address predicted demand.

b. The reliance on Commonwealth determination of university places for medical and allied health students and the limitations on control of future pipeline.

c. Clinical placements for healthcare students are compulsory, unpaid and exacerbate any existing financial stress experienced by students and directly disadvantages students from underrepresented equity groups, such as Aboriginal students or students from rural NSW, from either selecting or

completing their degrees. There is the opportunity for health agencies to enhance and/or embed paid employment options to students while they study. These can include Assistants in Medicine, Assistants in Nursing, Allied Health Assistants and Aboriginal Cadets (nursing and allied health) to ensure the future pipeline while promoting NSW Health as an employer of choice.

d. The difficulty in attracting and retaining workforce with strong competing markets (NDIS, private sector) and the need to rely on non-financial benefits of employment in the public sector.

e. The misconception that permanent workforce is the optimal employment condition for all staff. There is the need to maintain some temporary workforce to allow agile staffing to scale up and down when required.

f. The need to implement strategies to address the workforce maldistribution in NSW.

g. Under-utilisation of clinical capability and the need to ensure practice at the full scope of practice, supported by assistant workforces where appropriate.

Governance of education and training

148. The People and Culture for Future Health project (**MOH.0010.0274.0001**) identified an opportunity to review the structure and governance of education and training across the health system. The review identified:

a. Inconsistency in the investment into education and training across the health system, including by LHD, health organisation, and by health disciplines.

b. Structural variances in the education services at LHDs that is adding to the inequity of availability and access to training and development opportunities.

c. The need for a review of learning and development to identify current state challenges associated with educational governance and equality of access.

Richard Griffiths

Witness: Lucy Pinnock

16 / 07 / 2024

Date

16 / 07 / 2024

Date