Special Commission of Inquiry into Healthcare Funding

Statement of Jacqueline Dominish OAM

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

1. This statement 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 Workforce Part 2 Issues paper dated 16 September 2024.

3. I have provided a statement to this Inquiry dated 5 July 2024 (**MOH.0010.0243.0001**) (**First Statement**). This statement should be read in conjunction with my First Statement.

A. OPTIMISING SCOPES OF PRACTICE

4. It is important for the Ministry of Health (**MOH**) to be able to identify where scope of practice limitations are present in the workforce across nursing, midwifery, allied health, paramedicine and Aboriginal health. In my view, there are a number of activities that need to occur concurrently to enable responsiveness and delivery of priority programs of work.

5. In my view, connection between the MOH and professions across the system is a critical step to identify what they consider to be scope of practice limitations preventing the delivery of care to meet local service demands.

6. Another critical step is ongoing engagement with Chief Executives and Local Health District (**LHD**s) and Specialty Health Network (**SHN**) Tier 2 profession leads (such as District Directors of Allied Health, Nursing and Midwifery, People and Culture, and Executive Directors of Medical Services) to understand broader service demands and where optimisation of individual or team scopes of practice could unlock service capacity that would benefit the system more broadly.

7. Through these methods of engagement, the MOH can identify changes required to policy and regulation to unlock scope of practice. In addition, the MOH should also develop tools, resources and guidelines to empower LHDs/SHNs to lead work locally guided by

a consistent statewide framework to optimise scope of practice of individuals and teams in a timely manner.

8. Also, in circumstances where LHDs/SHNs have successfully piloted models and new ways of working which have been well evaluated, there should be an ongoing mechanism to enable this to be flagged at the state level to consider their suitability for packaging, sharing and scaling for system wide benefit, which I discuss further from paragraph 66 below.

(i) Developing and supporting top of scope of practice work

9. As I set out in paragraphs 43 to 44 of my First Statement, there is no universal definition of "scope of practice" in Australia, nor any universal agreement regarding what "working at the top of one's scope of practice" means. As referred to in paragraphs 45 to 47 of my First Statement, the Commonwealth Department of Health and Aged Care is currently undertaking the "Unleashing the Potential of our Health Workforce – Scope of Practice Review" (**Review**). Whilst the focus of this Review is primary health care, it is expected that the general findings of the Review will provide some assistance in defining key terms and will inform state-based reforms.

10. Independently of this Review, but still as part of considering the potential impacts of the Review's findings, MOH will need to develop a central policy position, framework, definitions and tools to assist with consistency across the state in describing, developing and applying scope of practice in the NSW Health context to support ongoing reform.

11. In my experience, defining "scope of practice" and determining what "working at the top of one's scope of practice" is for a clinical discipline, requires engaging across portfolios, agencies and disciplines, and with a wide range of stakeholders. It is also important to consider appropriate consultation with industrial associations during the process depending on what is being proposed. This is because the concept of "scope of practice" touches upon a broad range of issues, and can raise a number of questions including:

    a. How is the relevant clinical discipline defined? Is the title protected by law?

    b. How does someone qualify to practice the clinical discipline – for example, are there multiple pathways to qualification?

    c. How might a change in the scope of practice for the clinical discipline impact on:

i. award coverage and classifications, rostering, pay and other entitlements (for example, allowances)?

ii. funding arrangements?

iii. insurance cover?

d. Will a change in the scope of practice for the clinical discipline create an overlap with roles and responsibilities traditionally or historically considered to be within the scope of practice of another clinical discipline, and how will any issues of "professional tribalism" be approached?

e. How will a change in scope of practice be responded to, to ensure that issues pertaining to quality and safety (real or perceived) are addressed to reassure other professions and the organisation that the appropriate safeguards are in place.

f. Does it require regulatory change to enable the optimised scope of practice to be operationalised? For example, administration or prescribing of medications.

g. In what context is the scope of practice being applied, noting that scope is always context specific?

12. The experience I draw upon in making the statements set out in paragraphs 5, 6 and 7 includes my recent involvement in the Integrated Paramedic Workforce Project (**Project**), as referred to in paragraph 49(c) of my First Statement. The aim of the Project was to pilot the integration of paramedics within multidisciplinary teams outside of NSW Ambulance settings. Two 10-week pilots are about to commence at Mudgee Hospital Emergency Department (on 30 September 2024) and the Rapid Access Clinic/Hospital in the Home service at Wagga Wagga Hospital (on 14 October 2024).

13. This Project has provided a potential framework for a repeatable methodology for involving system leadership, multiple agencies, and stakeholder organisations which is needed to design and execute a successful innovative and somewhat controversial trial.

14. At the commencement of the Project, we had identified a notional set of new roles for paramedics for consideration, being:

a. Emergency Department Paramedic, and

b. Rapid Access Clinic/Hospital in the Home Service Paramedic.

15. The Project involved robust stakeholder engagement, including with the following NSW Health organisations:

    a. Agency for Clinical Innovation (**ACI**),

    b. Clinical Excellence Commission (**CEC**),

    c. eHealth NSW,

    d. HealthShare NSW ,

    e. Legal and Regulatory Services Branch, MOH,

    f. Murrumbidgee LHD,

    g. NSW Ambulance,

    h. Nursing & Midwifery Office, MOH,

    i. Office of the Chief Health Officer, MOH,

    j. Strategic Communications & Engagement, MOH,

    k. Western NSW LHD,

    l. Workforce Planning and Talent Development (**WPTD**) Branch, MOH, and

    m. Workplace Relations Branch, MOH.

16. In addition, there was ongoing consultation during meetings (face to face and virtual) and through formal correspondence with industrial associations, medical staff councils, clinical councils, consumer councils, local clinicians and executives.

17. The Project included an initial phase of work identifying and defining the current scope of practice for paramedicine within the NSW Ambulance Service. This required working with clinical expert paramedicine clinicians to create a document (**MOH.0010.0674.0001**) as a basis for discussions with the multidisciplinary team in each LHD to design a pilot role and scope for paramedics that was fit for purpose for their local setting.

18. A critical part of the initial stakeholder engagement process was to get 'buy-in'. This involved enhancing the knowledge and understanding of the medical, nursing and executive leadership team in each pilot setting of the existing paramedicine scope and

role. Once this understanding was developed, and there was recognition by all as to the value of paramedicine and its key strengths and attributes, a co-design process was able to occur to confirm the elements of the pilot paramedic scope of practice for each setting and therefore a paramedicine role description that would fit the local context (**MOH.0010.0673.0001**).

19. Over May and June 2024, face-to-face and virtual workshops were conducted with key medical, nursing, and executive stakeholders at both Mudgee Health Service and Wagga Wagga Base Hospital to determine how paramedics were to integrate within an established multidisciplinary team and to design the pilot service models.

20. Three main workshops were conducted with each pilot site through a combination of face to face and virtual sessions covering the following:

    a. Workshop 1: Paramedic Integration - Define the foundational elements of a paramedic's role.

    b. Workshop 2: Pilot Model Design - Define the remaining requirements for the pilot service delivery model.

    c. Workshop 3: Validation - Validate the pilot service delivery model, local operating procedure and agree on the evaluation approach.

21. Stakeholders who were consulted during the workshops included key medical and nursing leads, management and patient safety staff at each pilot site. Senior managers were also consulted for validation across the areas of Nursing Policy and Practice, Pharmacy, Imaging Services, District Education and Training, Clinical Councils and Emergency Nursing. Further consultations were then held by each LHD with consumer and Aboriginal community representatives who were all very positive and supportive about the pilot.

22. Once the specific scopes of practice were agreed, the project team went about developing position descriptions and training and orientation material to assist with onboarding and local credentialling. The intention behind creating these documents was to provide the governance and framework to enable the pilot to be operationalised and, if the pilot is successful, to have a suite of documents available which could be adapted for future pilots or wider implementation should that be deemed appropriate following evaluation.

23. This also enabled engagement with industrial associations during face to face meetings and sharing of the proposed pilot documentation via formal consultation, to allow them and their members the opportunity to better understand the detail of the proposed pilot and raise issues or concerns for further consideration by the project team before finalising the documents. Documents provided included the draft role descriptions, scope of practice, local operating procedure/service delivery model and expression of interest which was to be sent to paramedics to seek interest in participating in the pilots.

24. There was significant work involved in the Project because of the large number of stakeholders, and because complex issues arose in defining and designing a new scope of practice. However, it has had very positive results to date by getting buy in from critical stakeholders which has allowed the pilots to be operationalised.

25. I arranged an initial scope of practice forum on 27 September 2024 with state level clinical and professional leads and advisors across multiple disciplines within NSW Health. A representative from the Australian Health Practitioner Regulation Agency (**Ahpra**) was also present. These initial conversations focussed on setting the scene of the current state and the challenges and opportunities available to optimise scope of practice. Through group discussion we explored the complexities of multidisciplinary planning and collaboration without common terminology and processes to enact change at the state level. This was the first of what is planned to be several discussions which will then extend to LHD/SHN Tier 2 professional leads and other multidisciplinary clinicians in the system to collaborate on development of a statewide policy framework, tools and resources.

26. Another example of a pilot program for paramedicine is in the Tweed region. Although this pilot was not run by MOH, it sought to evaluate the use of Extended Care Paramedics working in collaboration with urgent care centres.

27. Northern NSW LHD and NSW Ambulance collaborated to deliver an urgent care service pilot for the Tweed community, in which Extended Care Paramedics work closely with the urgent care team and existing primary health care services in the Tweed region, to provide support to residents for urgent but non-life-threatening medical conditions in the comfort of their own homes.

28. The Tweed Urgent Care Service is currently available five days a week, from 8am – 4pm, through scheduled visits to residential aged care facilities, but will expand to offer care to people of all ages seven days a week in the coming months.

29. Three temporary full-time equivalent Extended Care Paramedics commenced on 12 August 2024 for the duration of the pilot and will conclude on 30 June 2025 when an evaluation will be conducted.

30. The Tweed Urgent Care Service and Extended Care Paramedic service is a component of the newly proposed urgent care service in the Tweed region, designed to manage the demand for services at the Tweed Emergency Department (**ED**), by transitioning low acuity non-admitted care currently delivered in the Tweed ED to an accessible multidisciplinary community-based service.

31. In my view, initiatives such as these pilot programs, together with staff and stakeholder consultation, can help shape how paramedics' scope of practice and their service offerings, can be optimised for the benefit of the NSW community. However, in order to be effective, potential pilots require staff and community consultation and incremental adoption to avoid unnecessary community alarm, ensure confidence in quality and safety and to set things up for success and future potential expansion.

(ii) Nursing and Midwifery

32. Paragraphs 69 to 73 of my First Statement referred to the use of the Emergency Care Assessment and Treatment (**ECAT**) program to support nurses to optimise their scope of practice in emergency settings. The development of the ECAT program is a good example of how protocolised programs to optimise models of care for nursing should be developed and implemented.

33. A protocolised program is one that develops standardised evidence-based protocols paired with appropriate training and education, to minimise unwarranted clinical variation, maximise the use of nursing skill sets and instil confidence in nurses to operate at optimal scope.

34. The State Directors of Nursing and Midwifery assessed that optimising the scope of practice for nursing could be achieved through further development of protocolised care programs.

35. Some preliminary suggestions for other protocolised programs which may be of benefit statewide include:

    a. nursing in general surgery,

    b. diagnostic order sets for surgical wards and community health, and

c. standardising scopes of practice for enrolled nurses and assistants in nursing to be able to undertake tasks such as cannulation and venepuncture.

36. To ensure the approach is well considered, there is consensus from the State Directors of Nursing and Midwifery that the development of such programs should be done in partnership with the Health Professional Workforce Unit, Nursing and Midwifery Office, State Directors of Nursing and Midwifery, Health Education and Training Institute (**HETI**) and relevant ACI Clinical Networks to undertake a horizon scan of potential priority areas that could be scoped in more detail for development and statewide scaling to optimise scopes of practice for nursing.

37. There is also an opportunity to review nursing and midwifery models of care to expand opportunities for collaborative (team) models. These are inpatient ward-based models of care where a team of nurses or midwives with varying levels of seniority and experience look after a group of patients. The senior nurse/midwife provides leadership and performs higher scope of practice functions while supporting and educating more junior/novice team members. The team could include graduate or new to practice nurses and midwives, enrolled nurses and assistant roles. These models have been shown, through systematic reviews of the available literature, to optimise the scope of practice of teams through enabling top of scope working for the senior members and supportive scaffolding of less experienced staff needing to build confidence and skills. It usually consists of all levels of nursing such as Registered Nurses, Enrolled Nurses and Assistants in Nursing.

(iii) Allied Health

38. Paragraphs 60 to 65 of my First Statement referred to the use of a Partnered Pharmacy Medication Charting model of care, and paragraphs 66 to 68 set out how remote x-ray operators can be used. These are two examples of optimising scope of practice for allied health professionals.

39. There are other potential practice improvements for Allied Health.

40. The **first** example involves physiotherapists in EDs being able to independently prescribe pain and anti-inflammatory medication for musculoskeletal conditions which they are already treating within their recognised scope of practice. This is currently in place in Queensland and the ACT after legislative changes. A proposal which has been submitted to MOH by physiotherapists from Illawarra Shoalhaven LHD is currently being

considered by the Health Professional Workforce Unit to determine any barriers to a NSW pilot program being designed and implemented.

41. The **second** example concerns independent flexible endoscopic evaluation of swallowing (**FEES**), which is a skill able to be undertaken by appropriately credentialled speech pathologists. Access to Ear Nose and Throat (**ENT**) consultation and equipment can be limited, due to competing demands e.g. ENT theatre lists, clinic and ward consultations. Independent scoping allows for trained speech pathologists to conduct the nasendoscopy either in a clinic or at the bedside on the ward to provide timely voice/swallow management, while the ENT consultation can occur post procedure as required e.g. for review of anatomical findings.

42. The practice of independent scoping by speech pathologists across NSW Health has been variable and mostly concentrated to most, but not all, major metropolitan facilities. It is usually dependent on trust and the strength of local relationships between the speech pathology department and ENT Specialists. Two settings where this has been in place for a long time is Royal Prince Alfred (**RPA**) Hospital (since 2010) and Concord Hospital (since 2006) to increase the access to instrumental assessment for both swallowing and voice without the need for ENT Specialists to be present. It is supported through formal training with a Clinical Specialist Speech Pathologist and ENT Registrar with documented competency assessment and final sign off from the Head of ENT (consultant level). FEES as an instrumental assessment is often preferable compared with Videoflouroscopy Swallowing Study (VFSS) where the patient has to attend radiology, especially in critical care areas.

43. The use of independent scoping by speech pathologists has shown to lessen demand on the ENTs, utilise the skills of speech pathologists, minimise wait times and minimise unnecessary other investigative procedures for patients. In addition, it also created additional opportunities for clinical research to be undertaken by speech pathologists on swallowing and voice disorders. Overall, it provides quicker access for patients to instrumental assessment resulting in faster and more targeted implementation of dysphagia rehabilitation and prompt return to oral food intake. Variations of these models are present across other facilities including Nepean Hospital, Prince of Wales Hospital (**POWH**), Campbelltown Hospital, Liverpool Hospital and Bankstown Hospital with other facilities across both metropolitan and rural areas hoping to implement similar models in the near future. This could be enabled further through support from the MOH with standardised tools, resources and credentialling frameworks developed by the NSW

Health Speech Pathology Advisory Network leveraged and formally endorsed by state level stakeholders and centrally accessible.

44. The **third** example concerns physiotherapy-led fracture clinics, which are a big opportunity to improve access to timely patient care in partnership with orthopaedics. There are some excellent examples of physiotherapy-led fracture clinics that have emerged over the past few years. With fracture clinics placing a huge demand on the time on both medical and allied health staff across the entire health system, redesigning the model of care releases orthopaedic surgeons and registrars in training to optimise their scope of practice and utilises the available skills and expertise of physiotherapists to the benefit of timely patient care.

45. A variation of this is seen in POWH, which runs a range of physiotherapy led orthopaedic clinics including a physiotherapy led fracture review clinic. The orthopaedic and fracture clinics at POWH see patients referred for follow up care from EDs and General Practitioners (**GP**s). Due to the large number of patients being referred to these clinics, patients often spend long periods of time waiting in the waiting room as well as to see a medical officer. This frequently leads to dissatisfaction with the service. In 2022 an innovative model of care whereby physiotherapists manage a cohort of patients with simple orthopaedic conditions was commenced. This Physiotherapy Led Fracture Clinic (**PLFC**) was implemented to run alongside the medical led fracture and orthopaedic clinics. In 2023 the number of conditions was expanded to increase utilisation of the PLFC. While generally positive outcomes were recorded for both the orthopaedic lead and PLFC, patient wait times and total length of time spent in clinics showed patients had a significantly lower waiting time, and time in the PLFC, and a higher level of satisfaction with the physiotherapy clinic experience, care and information provided.

46. The PLFC scored 95% very satisfied in overall clinic experience vs Fracture Clinic (79%) and Orthopaedic Clinic (75%), and 97% of patients in PLFC were very satisfied with the care and information given during their review versus 87% in Fracture clinic and only 67% in Orthopaedic clinic.

47. POWH also implemented a physiotherapy led shoulder/elbow orthopaedic clinic. In September 2022 there was a 513 day wait for category 3 patients to be seen for their initial assessment in the orthopaedic outpatient service with many of these patients not requiring surgical intervention being more appropriate for conservative management. A 6-month pilot of a new model of care was implemented, with a Senior Physiotherapist assessing, diagnosing and managing selected patients triaged to the non-urgent ‘365

day' waiting list. The clinic has resulted in a significant decrease in wait times for new assessments as well as a reduction in the number of patients breaching the 365-day waitlist. Following treatment by physiotherapists, patients have seen significant positive outcomes including significant reduction in the worst perceived pain score in the previous 24 hours and further significant reductions in pain and disability measures.

48. The **fourth** example concerns Sydney and Sydney Eye Hospital (**SSEH**), which is a quaternary referral centre for hand injuries in NSW. From 2018-2023 there was a 27.5% increase in new trauma referrals. To address this increase demand for service, in September 2023, an Advanced Practice Hand Therapy (**APHT**) closed trauma clinic was implemented.

49. From January – May 2024, 235 patients have been seen in the service which accounts for 10% of all new trauma referrals. The APHTs (occupational therapists and physiotherapists) have requested 53 x-rays and identified five patients requiring surgery following their independent assessment and subsequent escalation. The APHT clinic has redirected patients with simple closed hand injuries from traditional surgeon led clinics which has streamlined the patient journey and reduced demands on surgeons. The APHT's specialist skills in assessment; ability to request x-rays; and run the clinic concurrently with the hand surgeons' clinics has allowed for an improved integrated model of care within SSEH Hand Unit. If the APHT closed trauma clinic was to cease, there would be an increased delay in patients accessing care and increased waiting times for patients attending surgeons' clinics. Through ongoing evaluation the clinic plans to further expand referral criteria and formally evaluate patient experience.

50. The **fifth** example is the RPA Virtual Hospital's Virtual Fracture Clinic (**VFC**), which was launched on 13 October 2020 to offer a physiotherapy led virtual follow-up care service for patients with simple fractures and musculoskeletal injuries. The VFC at RPA Virtual Hospital offers a specialist outpatient service, combining virtual and in-person care. GPs and EDs refer patients directly to the VFC, where a physiotherapist and orthopaedic surgeon review cases and radiology scans.

51. The service aims to improve accessibility and reduce unnecessary in-person visits to the fracture clinic or ED, while maintaining high levels of patient satisfaction. Physiotherapists specialising in musculoskeletal injuries work in an extended capacity within the VFC, diagnosing injuries, providing care coordination, and escalating cases to orthopaedic surgeons when needed.

52. To enhance the model, VFC physiotherapists will soon have more autonomy, managing and triaging all referrals independently and consulting orthopaedic surgeons only when necessary. The clinic provides physiotherapy assessments at key intervals post-injury. Since April 2023, the VFC has commenced accepting referrals from Broken Hill Base Hospital in the Far West region, expanding its reach. Eligibility criteria includes patients being 16 years and over, non-operative fractures, certain joint dislocations, radiology confirmation, and the ability to participate in virtual consultations.

53. Since its launch on 13 October 2020, the clinic has had 2,459 admissions and 8,693 occasions of service. Over 10% of referrals now come directly from general practice, bypassing the need for ED visits. Patient feedback has been highly positive, with 90.4% rating their care as excellent, 95.7% willing to use virtual care again, and 93.1% recommending it to others. A post-discharge survey reveals high satisfaction, with 95.8% of patients confident in virtual symptom monitoring, and 78.6% stating their virtual appointment was as good as or better than an in-person visit. Patients have indicated that they "*could stay in bed and I was much more comfortable. I didn't have to wait in a waiting room and the appointment was efficient",* which highlights the service's convenience, professionalism, and ease of use, praising the time-saving benefits, comfort, and thorough care provided by the VFC.

54. The success of the model was enabled by securing buy-in from orthopaedics for the VFC. This included providing a clear model of care, a collaborative Steering Committee, regular performance data sharing, demonstrated patient and clinic benefits, recognition of physiotherapists' capabilities, effective communication, and the advantages of video consultations over traditional phone calls. The clinic regularly reviews various evaluation measures, including patient experience, activity levels, length of stay, incident reports, and ED re-presentations. RPA Virtual Hospital is collaborating with the Menzies Centre for Health Policy and Economics on economic evaluations of its model, with the first report awaiting approval.

55. These examples also show that it is important for scope of practice and service redesign changes to be introduced incrementally to ensure an increased understanding of the capability, competence and expertise of various allied health professions occurs to build trust and confidence in other clinicians. This will ensure more sustainable success so growth, expansion and scaling can happen more rapidly with strengthening of relationships, particularly with senior medical staff.

(iv) Aboriginal Health Practitioners

56. Paragraphs 33 to 35 of my First Statement outlined the role of Aboriginal Health Practitioners, and paragraphs 82 and 91 set out my view that Aboriginal Health Practitioners have an underutilised scope of practice.

57. The scope of practice of Aboriginal Health Practitioners could be enhanced through establishing improved governance and professional support models, and prioritising appropriately supported clinical placements during course completion and transition to practice. Currently, there are no Aboriginal Health Practitioner departments in hospitals or in LHDs/SHNs, which means there are minimal appropriate profession specific leadership and support structures.

58. To improve this, MOH, with support from LHDs/SHNs, could develop a best practice guideline on governance for Aboriginal Health Practitioners based on establishing clinical, professional and operational lines to enable the training, development, empowerment and safe practice of Aboriginal Health Practitioners.

59. There are also specific types of care that Aboriginal Health Practitioners could provide which are in demand in Aboriginal communities. This would increase the combined clinical and cultural safety outcomes of patients and could be addressed in the following ways:

    a. By supporting the use of renal dialysis in Aboriginal communities to reduce travel out of communities for recurrent care needs. In rural/remote areas this may be hindered by the availability of infrastructure such as dialysis machines and access to quality water sources.

    b. Within High Risk Foot Services, there is an opportunity for Aboriginal Health Practitioners to contribute to the clinical and cultural care of Aboriginal and Torres Strait Islander clients and assist with wound care, referrals, escalation, holistic health care and consumer and community engagement. Overall, the Aboriginal Health Practitioner workforce has the capacity to contribute to more effective early intervention and management which reduces the likelihood of individuals requiring lower limb amputation. To date, this has been limited by Aboriginal workforce numbers and funding of positions.

c. Aboriginal Health Practitioners could be utilised to do child health checks such as milestones and development, and their presence and expertise would encourage the Aboriginal community to feel safe to access care.

d. Aboriginal maternal and infant health services is also a space where there is opportunity for Aboriginal Health Practitioners to work in partnership with pregnant women and into the early stages of a child's life.

e. Vaccination, as described in paragraph 49(b) of my First Statement.

f. EDs, as described in paragraph 92 of my First Statement.

60. I am hopeful that exploring training requirements, authorising instruments, and amendments to legislation and policy could unlock the scope of practice for Aboriginal Health Practitioners, so that they are able to possess, supply and administer medications in a future models of care such as those listed above.

61. A barrier to developing a strong pipeline of Aboriginal Health Practitioners is ensuring they have good quality clinical placements across the state. Supporting clinical placement requires agencies to incorporate the Certificate IV Aboriginal Primary Health Care Practice into their standard student placement agreements, to capture their clinical placement hours and reduce the barriers into the pipeline through the use of standard educational support measures used by the other clinical professions. Often, it is difficult for new Aboriginal Health Practitioners to be supervised by other practitioners, such that they end up being supervised by another clinician who is not aware of the requirements of their program. In my view, there needs to be a simultaneous approach to both build the pipeline and establish the proper governance and clinical support for the emerging workforce so that people are training appropriately and not transitioning to practice in a way that restricts their scope of practice.

62. It is important to acknowledge that other clinical workforces such as allied health, nursing and medicine will need to play a part in accelerating the development of this workforce through agreeing to be supportive and empowering clinical supervisors of Aboriginal Health Practitioner students on clinical placement to enable the pipeline to grow with confidence and obtain practical experience needed to become qualified. This, paired with ongoing professional and collegial support in the workplace, will enable the workforce to thrive.

63. Building the Aboriginal Health Practitioner educator workforce will also be foundational to engaging both the entry-level and the emerging specialisation workforce pipelines. This will need to be enabled by award reform to establish these educator role classifications, in addition to clinical specialist roles, to enable progression in the profession and emergence of senior and junior workforce and department structures.

64. Another limitation to the scope of practice of Aboriginal Health Practitioners is a general misconception or misunderstanding by other clinical groups of the profession and what they are qualified and capable to do. A solution to this is a concerted strategy to improve the general understanding in the health system of the role of Aboriginal Health Practitioners. In addition, focussed work should occur with teams where a new Aboriginal Health Practitioner role might be established to generate an early and trusting environment of appreciative enquiry, listening and observing practice to recognise the expertise and value add of the role to the team and patient care.

65. As discussed in paragraph 91 of my First Statement, a big barrier to scope of practice for Aboriginal Health Practitioners is the current restrictions on possession, supply and administration of medications. Aboriginal Health Practitioners are trained in medication administration as part of their coursework, however, without further amendments to NSW Health policy and regulation this will be an ongoing barrier.

(iv) Scalable models of care to optimise scope of practice and evidence-based outcomes

66. My view is that an important part of optimising scopes of practice is the identification of well implemented and evaluated multidisciplinary and transdisciplinary models of care. In doing so, NSW Health should also look to other jurisdictions within and outside of Australia, to identify potential new workforce models and models of care to adopt, in consultation with the ACI, the Office of Health and Medical Research, and LHDs/SHNs.

67. My First Statement, at paragraphs 52 to 76, sets out a list of eight models of care that have the potential to be scaled up, potentially statewide. In my view, to ensure the ongoing pipeline of scalable models of care, it is important to have a level of governance over that pipeline, such as a peak committee which would comprise of key stakeholders. That committee would benefit from multi-agency membership and its purpose would be to identify models of care that prioritise evidence-based outcomes and optimising scopes of practice.

68. There is an opportunity for the WPTD Branch, ACI, the Office of Health and Medical Research, and LHDs/SHNs to work more closely together to identify opportunities to translate current clinical evidence into practice. This will enable redesign of workforce models to enable operationalisation of evidence-based models of care that improve patient outcomes.

69. While work needs to occur centrally, this also needs to be a flexible process whereby local clinicians and executive can work to advance translation of research into practice on a daily basis; however, when there are unique opportunities that could benefit from statewide adoption through evidenced-based models that focus on high value activities and outcomes, this should be coordinated and prioritised at a state level.

70. Good examples of how this has been done previously is the work completed by ACI, MOH and LHDs/SHNs through the Leading Better Value Care Program. This methodology could be used ongoing to continue to identify evidence-based models of care driven by current research and utilising the optimal scope of practice of individual clinicians and teams. https://www.health.nsw.gov.au/Value/lbvc/Pages/default.aspx

B. VIRTUAL AND MULTIDISCIPLINARY MODELS OF CARE

71. Virtual care can be initiated and provided in a number of ways including:

    a. Patient/community initiated: such as when a parent in the community concerned about their child dials HealthDirect to access the statewide VirtualKids Urgent Care Service. A registered nurse triages the call and connects the parent/carer to the right virtual/face to face service offering freeing up ED capacity.

    b. Clinician to patient initiated: such as an occupational therapist arranging a follow up telehealth outpatient therapy appointment with a recently discharged stroke patient or a clinician initiated interaction with a patient who is being monitored remotely and needs a change in treatment approach.

    c. Clinician to clinician initiated: where there is a clinician in one location such as a junior medical officer with a patient in a rural ED and they dial in/access another off site clinician or multidisciplinary team to enable thorough assessment and treatment in real time. An example of this is the statewide Telestroke service which enables remote video increased access to stroke treatment for people living in regional and rural areas. This service connects local ED medical officers to

specialist stroke physicians via video consultation to determine stroke type and treatment.

72. The *NSW Virtual Care Strategy 2021-2026: Connecting patients to care* (**MOH.0001.0371.0001**), outlines the steps NSW Health will take to further integrate virtual care as a safe, effective and accessible option for healthcare delivery in NSW.

73. The role of the WPTD Branch in this strategy is to work in partnership with the MOH Connected Care Team, ACI, HETI and LHD/SHNs to identify and build capability requirements to deliver care virtually across the system. Following completion of the Virtual Care Workforce Horizon Scanning and Scenario Generation Project in 2021, the first piece of work undertaken by WPTD was the development of a Virtual Care Capability Package based on recommendations from the project and the NSW Public Sector Capability Framework. This provided a blueprint of actions that could be taken at a local level to enable virtual care success, with a particular focus on capabilities required of Virtual Care Managers. To support LHDs/SHNs, in addition to the Virtual Care Capability Package, a standardised position description template for a Virtual Care Manager which incorporates these capabilities was also developed. Both the Virtual Care Capability Package and Virtual Care Manager Position Description Template were provided to LHDs/SHNs in August 2024 to enable their use.

74. Further work is required in partnership with the MOH Connected Care Team to improve ongoing engagement with tertiary education providers specifically around embedding virtual care in undergraduate clinical curriculum.

75. To support the development of virtual care education for clinicians, HETI has developed the *NSW Health Virtual Care Education Framework 2022-2026* which outlines 58 multidisciplinary competencies which are seen as baseline competencies for all NSW Health clinicians working across a range of settings and with different patient cohorts.

76. Virtual workforce models require collaboration between multiple parts of the health system to work. This is not only due to the potentially disparate physical locations of clinicians and patients, but also due to the reliance on hardware and software infrastructure to enable such virtual care to occur. Both the hardware and software must be functional and reliable to build the trust of clinicians in its use and in accessing the care pathway. This includes the IT equipment (and support) clinicians use to engage with other clinicians, directly with patients or used to monitor patients remotely. In addition, at

the clinician level, the skills, confidence and capabilities to integrate virtual care into clinical practice can be one of the biggest barriers to its success.

77. One potential issue, however, with such virtual care models is the potential confusion that may be experienced by clinicians in relation to responsibilities for a patient in such systems; specifically whether responsibility rests with a clinician who is physically in front of the patient, or the clinician/s from whom that clinician seeks specialist advice, or a combination of both. Whilst the traditional in-person hierarchy of clinical care, responsibility and transfer of patient care has its benefits, strict adherence to this hierarchy could become a barrier to true multidisciplinary care where patient treatment is provided by a team, and responsibility is shared between multiple practitioners. In reality, the sharing of responsibility for the patient's care when delivered virtually is no different to the sharing of responsibility when providing face to face care through multiple clinicians or teams.

78. There is a need with the increased emergence of virtual care models for these concepts to be socialised with clinicians to instil confidence while also ensuring that those responsible for the design and implementation of such models ensure appropriate systems of clinical governance are in place. The CEC has published this guidance for the system in the form of their two online publications:

    a. Embedding virtual care in safety and quality frameworks,

    b. An operational guide to applying embedding virtual care in safety and quality frameworks.

79. One of the critical factors to support rural nursing staff with provision of virtual care, such as remote monitoring, is in the initial purchasing and procurement of equipment that is reliable and integrates with all required clinical systems. There also needs to be dedicated change management support for clinicians to implement new tools and systems. If done poorly, this can be a source of stress and lost efficiency for nursing staff when they do not have confidence in the reliability of remote monitoring equipment. A critical example of this is the use of in-home telemetry that monitors cardiac patients' vital signs, which if abnormal may signal an immediate need for escalation of care to avoid a life threatening cardiac event. This can significantly impact on the wellbeing of nursing staff and other clinicians with their confidence and willingness to engage in providing virtual care for patients. This risks care provision reverting to more traditional and less efficient models, potentially perceived by clinicians as more reliable and safer,

of more frequent home visiting or unnecessary transfer of patients into hospital settings to monitor vital signs

80. Virtual Nursing Assist (**VNA**) is an example of a virtual care model in Murrumbidgee LHD which provides frontline nurses access to clinical nurse consultants 24/7 using virtual technology. The service is available to assist these frontline nurses to conduct triage, ED focused assessments, general assessment, treatment, and care. This particularly supports early career, newly recruited nurses or transient nurses. The VNA service supports care and treatment to patients presenting to Multipurpose Services, LHD sites and health services across the LHD.

81. There are potential further opportunities to build on this type of model through standardisation of Virtual Triage support, especially in some smaller communities with limited trained staff.

82. In considering advances for virtual care across NSW Health to support the workforce, a number of factors should be considered:

    a. Prioritisation of the services/locations across NSW Health where virtual care should be occurring with investment targeted to these locations.

    b. Leveraging the capability of existing infrastructure and experience of different LHDs to deliver/host virtual care services with a state-based offering such as has been recently done with Hunter New England LHD and VirtualKids Urgent Care as a hub and spoke model. This will centralise and build capability in specific groups of clinicians and prioritise high value care.

    c. Instilling confidence of clinicians in the clinical systems and resourcing to support them in using virtual services in addition to the privacy and security elements of systems to protect patient privacy and information.

    d. Prioritising areas of highest need for networked single discipline and multidisciplinary services including:

        i. Rural and remote locations due to the tyranny of distance and workforce shortages with lack of access to onsite support.

        ii. Metropolitan high volume services to support clinicians to manage increasing demand and take pressure off EDs and inpatient services.

e. Supporting the development of Aboriginal Health Workers and Practitioners to deliver virtual care and instil confidence of the Aboriginal and Torres Strait Islander community to access such care.

f. Strengthen communities of practice to better support implementation of virtual care/technological interventions across districts.

Jacqueline Dominish	Witness: Danijela Radovanovic
2 October 2024	2 October 2024
Date:	Date: