Special Commission of Inquiry into Healthcare Funding

Statement of Dr Josephine Burnand

Name:	Dr Josephine Burnand
Professional address:	1 Reserve Road, St Leonards, NSW 2065
Occupation:	Acting Medical Director, Health Education and Training Institute

1. I provided a statement to the Special Commission of Inquiry into Healthcare Funding (**Inquiry**) dated 11 July 2024 (**First Statement, MOH.0011.0017.0001**). This, my second statement, accurately sets out the evidence that I would be prepared, if necessary, to give to the Inquiry as a witness. The statement is true to the best of my knowledge and belief. This statement should be read in conjunction with my First Statement.

2. This statement is provided in response to Workforce Part 2 Issues paper dated 16 September 2024.

A. BACKGROUND

3. My name is Dr Josephine ("Jo") Burnand. My substantive position is the Deputy Medical Director at the Health Education and Training Institute (**HETI**). I was appointed to this role on 1 November 2021. Since 1 July 2024, I have been the Acting Medical Director at HETI, and I will be in this role for an initial period of six months. A copy of my curriculum vitae is at **MOH.0010.0267.0001**.

4. As set out in paragraph 3 of my First Statement, in my current Acting Medical Director role, I have responsibility for the HETI Medical Portfolio. This portfolio oversees the allocation of final year medical students to intern positions, provides support for all early career doctors during the two year prevocational period, and manages prevocational and a number of vocational training networks for NSW (including support and resources to senior medical practitioners responsible for the oversight of training programs and providing clinical supervision to ensure that inexperienced early career doctors are monitored and delivering safe patient care). The HETI Medical Portfolio is not responsible for managing clinical placements of medical students.

5. HETI has a limited role in the overall workforce landscape and, therefore, any comments I make in terms of workforce challenges are limited to the domains in which HETI

operates including in accreditation and oversight of prevocational training networks, oversight of NSW vocational training networks, and as a CPD Home, discussed further below.

B. PREVOCATIONAL TRAINING

(i) Allocation of interns

6. As set out in my First Statement at paragraphs 10 to 20, the HETI Medical Portfolio is responsible for allocation of final year medical graduates to intern positions across NSW. Intern allocation/recruitment is conducted at agreed dates nationally. All states and territories work in accordance with the agreed timeframe with respect to opening applications, offering positions and resolving duplicate acceptances across the jurisdictions.

7. The Prevocational Training Networks managed by HETI were originally designed to ensure that the prevocational trainee workforce was distributed across facilities in NSW, including rural, regional and outer metropolitan facilities and that trainees at all sites had access to education and training opportunities.

8. The Rural Preferential Recruitment (**RPR**) pathway is a further mechanism to assist with distribution of medical trainees, and provides an opportunity for medical students to apply for intern positions in selected regional and rural hospitals. The RPR pathway allows for trainees to remain rural for the duration of their prevocational training period. In some cases, trainees elect to undertake a term in a metropolitan setting. Of the 15 HETI Prevocational Training Networks, 8 include an RPR hospital and the majority of Prevocational Training Networks include a rural or regional hospital.

9. Applications for the RPR pathway are processed ahead of the Direct Regional Allocation and Optimised Allocation pathways. Any unfilled positions after the RPR process are either directly recruited to or included as a rotation within the particular Prevocational Training Network.

(ii) Prevocational medical training – exposure to General Practice

10. HETI's role in relation to prevocational medical training is set out at paragraphs 21 to 36 of my First Statement. In short, HETI is accredited by the Australian Medical Council (**AMC**) and approved by the Medical Board of Australia (**MBA**) as the prevocational

accreditation authority for New South Wales. Prevocational training in this context refers to the two-year period immediately following medical school.

11. The John Flynn Prevocational Doctor Program (**JFPDP**), which is coordinated by the Professional Practice Interprofessional Collaboration Portfolio in HETI, is funded by the Commonwealth and provides opportunities for Post Graduate Year (**PGY**) 1 - PGY5 doctors, who are not in vocational training, to gain exposure to rural general practice. Each JFPDP rotation for PGY1 and PGY2 doctors in NSW is accredited by the HETI Prevocational Accreditation Committee (**PAC**) and is included as a rotation within one of the 15 NSW Prevocational Training Networks.

12. The AMC National Framework for Prevocational (PGY1 and PGY2) Medical Training, which was introduced from the commencement of the 2024 clinical year, encourages more flexible approaches to training and, while not mandating a community or general practice term, encourages the development of rotations which provide prevocational trainees with exposure to general practice or community settings.

13. The implementation of the National Framework provides NSW with the opportunity to explore more flexible training pathways, pending identification of funding sources, such as the development of a rural LHD prevocational training pathway.

14. As the organisation with responsibility for oversight of the prevocational training period, HETI also has responsibility for leading the implementation of the National Framework for Prevocational Medical Training. HETI is very supportive of increasing exposure for prevocational trainees to general practice. The further expansion of prevocational general practice terms is limited by funding, traditionally provided through the Commonwealth, for both positions and supervisor time, and the current availability of the prevocational trainee workforce.

15. HETI could also potentially have a role in the development of a Rural LHD prevocational training pathway. This could operate as a bespoke pathway, in collaboration with LHDs and existing NSW Prevocational Training Networks. The aim would be to create a training pathway for regionally located medical students to complete most of their training in smaller facilities (such as South East Regional Hospital or Bathurst Hospital, instead of the larger RPR hospitals such as Wagga Wagga), while still having opportunities to complete rotations in larger regional facilities. There would need to be funding to develop, pilot, and evaluate a Rural LHD prevocational training pathway. There are many

advantages to the existing NSW Prevocational Training Networks, so it will be important to manage any risks associated with disrupting existing pathways and arrangements.

C. VOCATIONAL TRAINING NETWORKS

16. HETI's role in vocational training is set out in my First Statement at paragraphs 37 to 58. HETI provides oversight to the NSW vocational (specialty) training networks to support training for the relevant specialty, and also monitors and reviews performance. It is a point of escalation for issues, and assists with curation of education resources. The HETI vocational training networks currently include Basic Physician Training, Psychiatry, Paediatrics, Emergency Medicine, Radiology, Advanced General Medicine, and Medical Administration.

17. The vocational training networks feature different sites working together to provide more integrated training opportunities. Their genesis was generally to promote high quality training and ensure equitable distribution of the trainee workforce.

18. A significant challenge for HETI in fulfilling its role in vocational training networks is that it is not involved in all vocational training programs. This at times leads to confusion across the system. The reason why HETI is involved in some vocational training networks but not others is due to funding and workforce requirements. The Ministry of Health determined which vocational training networks would be established and provided funding to achieve this.

19. In the existing vocational training networks the number and location of training positions is determined by the employing LHD (and not HETI) and are subject to sites meeting accreditation requirements set by the respective College. HETI has a coordinating function which could be expanded, pending additional funding, to include additional specialties. There is potential for HETI's current role in vocational training to expand across all training networks beyond the current specialities and adopt the current governance structure that has been successfully applied within the current HETI vocational training networks. The expansion of vocational training networks could be directed to those specialties with workforce need or where access to training requirements is challenging, and would be, as is the case with the current vocational training networks, determined by the Ministry of Health. This would build on the success of existing vocational training networks in creating equitable access to high quality education and training for trainees, no matter where they are located.

20. There are challenges with providing sufficient allocated time to senior doctors to provide the necessary training and supervision required by specialist colleges, particularly for trainees located in outer metropolitan, regional and rural hospitals.

21. Senior doctors face increasing competing priorities between the time allocated for direct patient care, time to supervise trainee doctors who are providing front line clinical services, and time to provide training and education of those trainee doctors, the latter being an investment into the specialist medical workforce of the future. As trainee doctors progress through training, there is an implicit expectation that they require less direct clinical supervision, pending the complexity of the clinical tasks, however, even senior trainees still require senior doctors with the time to engage with them in education and training activities. While historically this has been absorbed into the daily work of senior doctors, as clinical demands have increased, the time for senior doctors to spend on education and training activities has been eroded.

22. The establishment of positions of Directors of Training within LHDs has been a strategy to address these challenges and assist with providing senior doctors with adequate time and resources to oversee the education and training of trainee doctors. HETI has a coordinating function through the governance structure described in my First Statement at Section E for selected vocational training programs.

23. Some colleges are exploring other options for supervision, such as remote supervision. These include the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine. While remote supervision has a role across the medical training trajectory and may be appropriate in certain clinical settings, it is often inadequate to properly support trainees in the early stages of training as they gain competence in clinical skills, clinical judgement and procedural work, while ensuring patient safety.

24. There remains an area of potential tension for training programs where there may be scope to increase trainee positions, primarily to reduce workforce shortages in regional and remote areas, but also an obligation to ensure patient safety which is limited by supervisor availability.

D. NON-SPECIALIST TRAINING

25. A significant number of junior doctors working in NSW public hospitals and providing frontline clinical services are working in positions which are not accredited as either prevocational training positions or specialist vocational training positions.

26. In general, the number and location of these positions is determined by LHDs in response to clinical demand. To provide clinical services in the public health system across the 24 hour cycle, many more junior and middle grade doctors are required than will ultimately achieve a specialist qualification. Doctors employed in these positions are generally PGY3+ and the positions include unaccredited training positions, unstreamed or streamed Senior Resident Medical Officer (**SRMO**) roles, and career medical officer (**CMO**) roles. These positions may be filled by a range of doctors including those on temporary contracts who may ultimately progress to an accredited vocational training position in following clinical years, others who are uncertain of career direction but wish to remain on temporary contracts working in so called 'service jobs' within the NSW Health system, international medical graduates, and doctors working as locums.

27. A challenge for this heterogenous cohort of doctors is in providing appropriate support and opportunities for education and training. For those who want to remain with NSW Health but do not want to complete fellowship training, a further challenge is how to structure a meaningful and supported career as a highly skilled, but not specialist trained, doctor working within NSW Health. Such multiskilled medical officers are required for clinical service provision, but this is generally not characterised within the system as a clear career pathway with formal training and recognition.

28. Currently relevant to HETI is:

    a. the Hospital Non-Specialist State Training Council, which aims to ensure structured and relevant professional development of the PGY3-5 non-specialist medical cohort working in NSW hospitals.

    b. the NSW Surgical Skills Training Network which supports trainees who work in unaccredited positions within surgery. This is discussed in the NSW Surgical Training Network Review (**MOH.9999.3083.0001**) which found that this Network provides unique support for unaccredited staff not in college positions to continue

professional development, providing a means for the oversight of wellbeing, career coaching and mentoring.

c. HETI CPD Home, the focus of which is for doctors in their earlier years of medical practice and not on an accredited training pathway. The HETI CPD Home supports doctors in meeting their continuing professional development requirements with the MBA through providing expert advice to non-specialist doctor members on how to develop professional development plans and access existing, appropriate education and training activities. The HETI CPD Home is accredited by the AMC.

29. HETI could potentially have a role, in collaboration with LHDs, to oversee and support training programs for all non-accredited medical officers, with the aim of providing statewide coordination and governance, support and training for supervisors and contributing to the professional development and training pathways for doctors wanting a career within NSW Health as a non-specialist doctor.

30. Consideration should be given to the creation of a governance structure that is similar to the current vocational training programs, that has capacity for scalability and support of doctors not in specialist training positions, but who are providing a critical component of the medical workforce for NSW Health. The development of a well-defined training pathway would allow those who choose not to pursue fellowship training to progress in a career as a multiskilled medical officer, providing front line clinical services as a valued member of the healthcare team.

31. Assuming availability of adequate funding, the scope may include:

a. the development of a state level governance committee, incorporating the former hospital non-specialist and surgical skills committees, but expanding to include other cohorts,

b. the development of an evidence-based framework to support the supervision, education, training, support, and wellbeing of doctors working in unaccredited roles,

c. the development of guidelines for LHDs which articulate best practice principles for optimising the education, training, and support of doctors working in unaccredited role,

d. in collaboration with the Ministry of Health Workforce Planning and Talent Development branch, exploring potential training pathways and networks,

e. the development of training resources,

f. supporting collaborative forums for supervisors of doctors working in unaccredited roles, including training for supervisors in mentoring and career counselling,

g. providing a centralised portal for sharing of education and training resources, and

h. supporting statewide scaling of education and training opportunities.

E. PREVOCATIONAL TRAINING IN SOUTHERN NSW LOCAL HEALTH DISTRICT AND THE ROLE OF HETI

(i) Background

32. The role of HETI (previously named the Clinical Education and Training Institute, and prior to that the NSW Institute of Medical Education and Training) in relation to the Australian Capital Territory (**ACT**) was as follows up until 2010:
    a. Allocation of interns to a prevocational training network, and

    b. Accreditation of ACT hospitals for prevocational training.

33. An ACT prevocational training network previously included:

    a. Two hospitals within the ACT – Canberra Hospital and Health Services, and Calvary Public Hospital Bruce (known as North Canberra Hospital since July 2023), and

    b. Two hospitals within the footprint of Southern NSW Local Health District (**SNSWLHD**) – Goulburn Hospital, and Bega Hospital (now South East Regional Hospital).

    In this statement, the above prevocational training network is referred to as the "**ACT Prevocational Network**".

34. Up until 2010, the ACT Prevocational Network was included in HETI-convened prevocational education and training activities, such as the Directors of Prevocational Education and Training (**DPET**s) forum, and via representation on relevant HETI

committees, such as the Prevocational Training Council and the Prevocational Accreditation Committee.

(ii) Process of change

35. In 2006, the Council of Australian Governments (**COAG**) agreed to guarantee internships for all Commonwealth Supported Place (**CSP**) medical graduates. All states and territories developed intern priority lists, and each state and territory guaranteed intern positions for CSP graduates from their state/territory universities.

36. Before 2008, the ACT had no local supply of medical graduates, however this changed with the creation of the Australian National University (**ANU**) medical school. Its first students graduated at the end of 2007 and applied for internships to be undertaken in the 2008 clinical year.

37. Graduates of ANU were classified as interstate graduates under the NSW Priority Category and were therefore a lower priority category than domestic graduates from NSW based universities. This presented challenges for ANU graduates applying to the ACT Prevocational Network through the NSW intern allocation process.

38. From 2010, ACT Health undertook its own intern allocation/recruitment process to the ACT Prevocational Network, which continued to include hospitals in the former Greater Southern Area Health Service. My understanding is that prevocational trainees allocated by Canberra Health Services are employed by ACT Health, even when rotated to SNSWLHD facilities.

39. It is my understanding that the then Greater Southern Area Health Service was consulted, and its preference was to remain part of the ACT Prevocational Network.

40. Initially HETI continued to accredit ACT Prevocational Network hospitals, however this also changed. In approximately 2014, the Canberra Regional Medical Education Council (**CRMEC**) was established as a Ministerial Council providing strategic advice to the ACT on postgraduate medical education and training. The CRMEC is accredited by the AMC as the prevocational accreditation authority in the ACT.

(iii) Current position

41. Health services within the footprint of SNSWLHD which are accredited for prevocational training remain part of the ACT Prevocational Network. This network is the responsibility of the ACT. HETI is aware of the number of PGY1 positions ACT Health requires each

year for SNSWLHD, but does not have any direct role with prevocational trainee positions or rotations in the ACT Prevocational Network.

42. The CRMEC accredits all prevocational training positions within the ACT and SNSWLHD footprint. This is a joint accreditation process with HETI, although CRMEC takes the lead. The NSW Prevocational Accreditation program appoints a NSW surveyor to join the ACT led accreditation team. While the final accreditation report for NSW based facilities accredited through CRMEC is provided to the NSW PAC for noting, the NSW PAC does not have any input into the decision.

43. The current DPET at South East Regional Hospital, Dr Nathan Oates, is invited to all HETI DPET meetings and DPET forums. Invitations are additionally extended to the DPETs of both Goulburn and Moruya Hospitals. NSW based DPETs are included in communications to DPETs from HETI, including DPETs located in those NSW facilities not under the direct oversight of HETI.

44. Information about applications for internship within NSW sites, with the exception of those NSW facilities under the oversight of ACT Health, are provided at https://www.heti.nsw.gov.au/education-and-training/courses-and-programs/medical-graduate-recruitment.

(iv) Prevocational Scholarships and Incentives – SNSWLHD, NNSWLHD

45. Junior doctors working within SNSWLHD and Northern NSW Local Health District (**NNSWLHD**) are eligible to apply for the Rural Medical Training Scholarships (**RMTS**), which are administered by the Medical Portfolio of HETI. All medical trainees (including PGY 1 and PGY2) are eligible to apply for this scholarship. In 2023/24, a total of 6 scholarships were awarded to trainees from SNSWLHD.

46. The JFPDP is referred to above. Eligible sites in the SNSWLHD footprint can access JFPDP funding to provide a general practice term for trainees, which may include PGY1s and PGY2s. These doctors are then allocated to those rotations through the ACT Prevocational Training Network.

47. Further, a $3,000 scholarship is provided to Rural Generalist Program Trainees in their Advanced Skills Training year (PGY3+). PGY1s and PGY2s are not eligible for this scholarship.

48. All ACT and Queensland graduates can apply through the four NSW Internship pathways, that is the Rural Preferential Recruitment (**RPR**), Aboriginal Medical Workforce, Direct Regional Allocation and Optimised Preference Pathway. However, as interstate graduates, they are not guaranteed an intern position in NSW and they rank lower on the NSW Health Priority List than NSW domestic graduates (**MOH.0010.0059.0001**). While category 2 and category 3 applicants are not guaranteed a position in the NSW intern allocation, in recent years they have all been offered a position. In the case of the RPR pathway, which is a merit-based application process, all applicants are treated equally with respect to their state of origin.

49. In addition for SNSWLHD, the ACT sets the rotations of interns through the ACT Prevocational Training Network. There is potential for the ACT to consider a RPR type arrangement such as operates in NSW.

50. In relation to the NSW RPR pathway application process, the application process is set out in the *Rural Preferential Recruitment pathway, NSW Medical Intern Recruitment for the 2024 Clinical Year* document (**MOH.0010.0684.0001**).

51. In addition to their general intern online application, applicants complete a separate application through the JMO Recruitment and Onboarding (**ROB**) Portal for each RPR hospital where they wish to work. Applicants must address selection criteria and following review may be invited to interview by the rural hospital/s. Following a preference match HETI makes conditional offers to candidates.

52. The Rural Doctors Network (**RDN**) manages the rural cadetship process, including eligible hospitals where candidates can complete their return of service. HETI does not have any oversight of this.

(v) Opportunities

53. Albury Wodonga Health – Albury Campus has 10 PGY)1 positions funded by the Ministry of Health. It also has additional intern positions filled through Victoria. Albury is a Rural Preferential Recruitment (**RPR**) facility and is included in HETI Prevocational Training Network 8 with St George Base Hospital, although there are no rotations between the facilities. As a RPR facility, recruitment is merit based with Albury interviewing candidates. Following a preference match, HETI makes conditional offers to candidates. Interns appointed to Albury are on Victorian contracts and work to Victorian term dates.

54. The development of a hybrid model for the ACT Network, where NSW becomes responsible for rotating some trainees to current SNSWLHD facilities would need to address a number of issues, notwithstanding that there are national workforce shortages with NSW having close to 95 intern vacancies at the commencement of the 2024 clinical year. It is anticipated that there will continue to be intern vacancies across NSW for the 2025 clinical year.

55. Further, the ACT operates on different term dates compared with NSW. Prevocational trainees working in SNSWLHD follow the same term dates as the ACT. Currently ACT has four prevocational terms per year compared with five terms per year in NSW.

56. Requests have been received from the SENSW Regional Training Hub, and from SNSWLHD, to discuss the role of HETI in relation to prevocational trainees. A meeting was held on 26 September 2024 between SNSWLHD and HETI to discuss possible approaches, including on the issue of increasing the visibility of facilities within SNSWLHD to potential intern applicants. During the meeting it was agreed that HETI and SNSWLHD would continue to work to explore potential approaches to addressing issues identified.

Dr Josephine Burnand

4 October 2024

Date

Witness: Lucy Blair

4 October 2024

Date