Special Commission of Inquiry into Healthcare Funding

Statement of Richard Griffiths

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

2. I have provided two statements to the Inquiry dated 16 July 2024 (**MOH.0011.0022.0001**) and 2 August 2024 (**MOH.0011.0039.0001**). This statement should be read in conjunction with these statements.

3. This statement is provided in response to Workforce Part 2 Issues paper dated 16 September 2024 (**SCI.0011.0468.0001**).

A. WORKFORCE MALDISTRIBUTION

4. I agree that there is a maldistribution of workers in NSW, with more workers in metropolitan areas compared to regional and rural areas. Whilst the Ministry of Health (**MOH**) can and does have financial, policy, and other levers it can access to attempt to correct this maldistribution, it should be noted that it does not control all the levers. As a result, attempts to correct maldistribution are disjointed, as there are diffuse responsibilities, powers, and planning between jurisdictions and stakeholders regarding workforce maldistribution.

5. This section seeks to set out various methods at various points in the workforce pipeline that could be altered to mitigate maldistribution.

(i) Centralised and standardised career pathway awareness and graduate programs

6. Currently MOH provides a ‘Virtual Careers Fair’ program to increase high school student awareness of NSW Health careers. MOH also attends rural and regional careers expos targeted to high school students in years 9-12.

7. There is an opportunity to scale up examples of good practice into a standardised system wide approach that starts at the beginning of the workforce pipeline. This should include a high school and vocational education sector work experience program to maximise exposure to and learnings about the various careers in the health system and the way they work together.

8. The aim of this standardised program would be to promote throughout high schools, especially in rural and regional areas, the various careers that can be pursued, particularly those where people can stay in regional and rural areas.

9. Currently, some public health organisations also provide work experience or immersion experience programs for high school students to build on their interest in a health career. They provide student placements for high school students studying VET in Schools programs, for example Certificate III in Health Services Assistance (Assistant in Nursing) and Certificate III in Allied Health Assistance. Another strategy targeting high school students is School Based Apprenticeships and Traineeships (SBTs) run by the Department of Education.

10. Under a standardised program, there would be additional ways in which health students, particularly Allied Health students, can be incentivised into early career employment within NSW Health. This could include conditional letters of offers of employment which are provided prior to Australian Health Practitioner Regulation Agency registration. This would speed up the on-boarding process and reduce risk of losing preferred candidates to the private and NDIS sectors.

11. Another option could be re-establishing graduate programs with a more structured pipeline and regional rotation. Such programs would require a strategy to be developed centrally, to mitigate the financial risk of having a certain amount of graduates when we are unable to precisely forecast demand.

12. A standardised new graduate program could be established in a number of ways. One way could be via a centralised annual recruitment process to identify existing positions from each Local Health District (**LHD**) / Specialty Health Network (**SHN**) that could be converted to a new graduate position for specific Allied Health professions which are time limited (for example, 1 or 2 year contracts) so there is a steady stream of Allied Health graduates into the system. Once their contract expires they could apply for ongoing permanent roles.

13. Alternatively, LHDs could identify these potential new graduate roles themselves and run their own recruitment on a time schedule that is centrally set and required to be followed across the State. Once the Allied Health graduates are employed by each LHD, their onboarding, development and experience could be supported and coordinated at a State level. This could be a virtual graduate program led by the Health Education and Training Institute (**HETI**) (which could have a State curriculum, leveraging the content from the Allied Health Rural Generalist Program), as well as localised professional development and rotations across clinical areas and potentially other sites. A recent project to explore the education needs of the Allied Health workforce, undertaken by my branch in collaboration with the Chief Allied Health Officer, highlighted that adding in support from Allied Health Educator roles would be a key enabler to supporting Allied Health clinicians with the burden of ongoing learning, development and professional supervision for early year clinicians which we need as our future workforce. A copy of the project report is exhibited to this statement (**MOH.0010.0683.0001**).

14. Fully realising the value of Allied Health Educators has the potential to make a significant contribution to a sustainable and value-based healthcare system that meets the evolving needs of the NSW population. The Workforce Planning and Talent Development Branch (**WPTD**) could assist LHDs and SHNs with the growth of this workforce through development of a statewide strategy to produce standardised resources such as position descriptions, and establish communities of practice in partnership with the Chief Allied Health Officer, Directors of Allied Health and HETI. In my view, this would allow promote the growth of the Allied Health Educator workforce, which is then required to reinforce the student and new graduate pipeline and ongoing development of the Allied Health workforce.

15. An example of a current Allied Health graduate program is the Western NSW Allied Health Rural Generalist Program, run by Western NSW LHD. It is a structured two-year program that supports recently graduated Allied Health professionals as they transition to the workplace and develop rural generalist clinical skills. This occurs through preceptorship and mentoring, ensuring access to supervision, a structured learning and development program and the ability to undertake clinical rotations across a range of hospital and community health settings in the District.

16. The Program began in February 2023 when 15 Allied Health graduates in five professions (dietetics, occupational therapy, physiotherapy, social work, and speech pathology) commenced in supernumerary positions across Bathurst, Orange and Dubbo. A second intake of four graduates commenced at Dubbo Health Service in February

2024. At 12 months, the program had achieved a retention rate of 80%. The Program has been expanded to provide support, networking, and education to all Allied Health graduates who have recently commenced their professional careers in the District in 2023-24. The Program currently supports 50 graduates across the Allied Health professions (expanding to pharmacy, psychology and radiation therapy in 2024) and seven locations in the District.

17. Another example is the graduate rotational program for two speech pathology and two occupational therapy clinicians, established in partnership by Sydney LHD (**SLHD**) and Far West LHD (**FWLHD**). This provided an opportunity for these clinicians to:

    a. spend their first-year clinical rotation across rural and metropolitan sites, gaining experience in adults, paediatrics, acute and subacute settings

    b. develop their clinical skills and knowledge, and

    c. develop their professional skills, such as flexibility and adaptability to different clinical settings.

18. One clinician from each discipline spent the first six months in SLHD. After six months, the clinicians rotated to the other setting in either Broken Hill or SLHD. Support structures included a virtual and face to face clinical supervision model, and inclusion in the established SLHD educational program 'Grad Start' by live streaming sessions to Broken Hill. The education program actively promoted interaction between Allied Health clinicians across rural and metropolitan sites. The program is being evaluated through pre-and-post surveys of the new graduates' experiences, clinical and non-clinical activity and performance data.

19. One current barrier to a standardised, statewide Allied Health graduate program is the ability to create and fund dedicated roles assigned for new graduate Allied Health positions as occurs in nursing (Grad Start) and medicine (prevocational allocation). LHDs are reluctant to establish such roles due to the fractionalisation of Allied Health positions and the dispersed nature of Allied Health disciplines in the health system.

20. In my view, programs of this type will require more leadership from the centre, although this could occur through the use of existing People and Culture workforce across the system, which is discussed further at paragraph 101 below. It will also require significant investment through funding from Government.

(ii) Commonwealth Supported Places funding expansion

21. An example of a lever that can be used to seek to address maldistribution is the targeted allocation of Commonwealth-Supported Places (**CSPs**) to rural and regional training centres.

22. It is my understanding that the number of medical CSPs is capped for medicine. Between 2014 and 2023 there had not been an increase in medical CSPs, until an increase of 80 medical CSPs for rural places in 2023. NSW received 15 for the University of Wollongong.

23. I understand that the Murray Darling Medical Schools Network was established through redistribution of existing CSPs. The Murray Darling School Network included establishment of the new Charles Sturt/Western Sydney medical school and expansion of the medical programs at Wagga Wagga (University of New South Wales) and Dubbo (University of Sydney).

24. Putting aside the question whether the number of CSPs is sufficient for current demand in NSW, in my view, CSPs should be specifically targeted at rural and regional areas such as occurred with the Murray Darling Schools Network, in order to place students in these areas during their study.

25. MOH should and would have to plan such usage with the Commonwealth and other jurisdictions so that the pipeline of new graduates can be developed in rural and regional areas. In doing so, a balance would have to be struck with the CSPs assigned to metropolitan areas.

26. However, there are structural limitations on the effectiveness of the targeted use of CSPs to address maldistribution. The first is that people want jobs in areas where they want to live and as such, even in rural areas, most people live in a town or city such as Dubbo or Wagga Wagga, rather than smaller and more isolated locations. An associated problem is that, even presuming that there is a pipeline of workforce to fill vacancies in smaller and isolated locations, there is inadequate funding and supervision challenges for such positions in those rural and regional areas.

27. The second limitation is that the universities determine available places based on demand by students, rather than health system need.

28. In an ideal situation, either one party controls all the levers available to address maldistribution, or alternatively all the parties who control separate levers are in agreement as to their use, noting that obtaining agreement may be very challenging.

29. For example, for an issue such as the quantum and distribution of CSPs, the Commonwealth might determine numbers in consultation with the universities and the States, as the variable spread of universities across Australia requires a national solution. This must then involve State workforce planners and education departments, the Commonwealth's Health and Education departments, universities, and other stakeholders to discuss the projected shortages of health graduates. All parties must share what each party has projected the shortfall to be, and then work together to attempt to resolve the problem.

(iii) Midwife shortages

30. The numbers of midwives graduating and projected to graduate are falling behind demand.

31. There is a recognised shortage of midwives across Australia and internationally. Work is currently being undertaken by the Commonwealth and at each State and Territory jurisdiction. In NSW, the midwifery shortage is a result of an aging workforce, reduction in worked hours, accessibility to training programs in regional/rural areas, a maldistribution of employees across metro and regional/rural areas, and increased complexity of maternity care needs.

32. There are two pathways to becoming a midwife. The first is through completing a Bachelor of Midwifery. The second is Midstart, which offers post graduate study in midwifery to registered nurses to transition to midwives.

33. In relation to university Bachelor of Midwifery pathway, our workforce modelling has identified an undersupply. There are several factors contributing to this undersupply, including the availability of clinical placements (determined by LHDs and private hospitals) and geographical distribution of university programs, which are generally face to face and not located in rural areas. Of note, the alternate postgraduate pathway, MidStart, has been the stronger pathway in terms of numbers of midwifery new starters in NSW Health.

34. My branch has commenced a campaign offering $20,000 sign on bonus incentives for midwives across all Modified Monash Model (**MM**) 3 to MM 7 locations. In six months'

time, we will complete an evaluation to determine whether the sign on bonus has assisted to attract and retain midwives to rural areas.

35. NSW Health also offers scholarships and grants administered by MOH's Nursing and Midwifery Office to support existing and future nursing and midwifery students, as well as Registered Nurses (**RNs**) and midwives already working in NSW Health. Some of these are specifically targeted to grow either the Aboriginal and/or rural workforces.

36. In my 16 July 2024 statement I referenced the available cadetship and scholarships programs for nursing and midwifery at paragraph 87. Examples include:

    a. Rural undergraduate scholarships intended to attract people living in rural areas into nursing and midwifery. Scholarships of up to $5,000 are available to eligible students from rural NSW who are undertaking their first year of a Bachelor of Nursing or Bachelor of Midwifery degrees. Scholarships are awarded based on the student's residential location and areas of workforce need.

    b. Undergraduate clinical placement grants support nursing and midwifery students to experience a diversity of clinical experiences across NSW rural and metropolitan areas. Grants of up to $1,000 are available for nursing and midwifery students undertaking a clinical placement more than 150 kilometres from their university campus.

    c. Nursing and Midwifery postgraduate scholarships support the professional development of NSW Health nurses and midwives, including the transition into specialty areas of practice. The intention is to grow and sustain a knowledgeable and skilled workforce as well as being an attraction and retention strategy for NSW Health. There are two models:

        i. Individual Scholarships: up to $10,000 paid directly to the applicant to support professional development in a range of areas including Midwifery (priority), Clinical Nursing, Education, Management and Nurse Practitioner.

        ii. Education contracts: fully funded graduate certificates for targeted clinical specialties in areas of workforce need. Currently these specialties are Acute Care, Aged Care/Gerontology, Alcohol and Other Drugs, Child and Family Health, Critical Care, Neonatal Intensive Care, Neonatal Special Care Nursery, Oncology, Paediatrics, Perioperative, and Rural and Remote.

d. Rural postgraduate midwifery student scholarships are provided as a "Grow your own" strategy for midwifery to support small rural maternity units. The scholarships support the sustainability of these small units by funding a local RN to train as a midwife. The funded student midwife position is in addition to their existing full-time equivalent establishment profile. NSW Health has funded more than 130 of these training positions in the last 12 years (approximately 10 per year), with a total investment of $11 million. Managers report that in many instances this strategy has delivered the midwifery workforce needed to sustain these small rural maternity units and keep them open.

e. The NSW Aboriginal Nursing and Midwifery Cadetship Program provides support and assistance to Aboriginal people studying an undergraduate nursing or midwifery degree.

f. Cadetships that cover study allowances, general support allowances, paid employment arrangements during study, support from mentors, and opportunity to undertake graduate employment.

g. NSW Health offers postgraduate scholarships of up to $10,000 to Aboriginal people working as a RN or Registered Midwife in NSW Health.

h. The New Graduate Nursing and Midwifery Rural Support Incentive (administered by HETI) is available to new graduate nurses and midwives relocating to take up employment in identified rural or remote LHD locations. The incentive supports relocation costs for non-local graduate RNs and midwives seeking employment in rural NSW Health. The rural support incentive is available until 2026.

37. Making available the full range of scholarships and support, as outlined in paragraph 87 of my 16 July 2024 statement, to all workforce disciplines would assist to expand interest in NSW Health careers. At present, there is an inconsistent catalogue of scholarships and varying support in each discipline that has been developed separately over time. Instead of a standardised system managed centrally, the 'ad hoc' nature of these programs reflects history, variable interest from previous governments, and grants offered from external stakeholders.

(iv) Incentive programs

38. Incentive programs are an important method to attempt to address maldistribution. Paragraph 87 of my 16 July 2024 statement sets out examples of incentives to support

students studying health related courses. Some of those scholarships are conditional, meaning they provide a payment but are subject to an individual having to undergo a particular period of time in a rural or regional setting (MM3 to MM7 locations).

39. Incentives can take the form of financial or non-financial supports for existing and prospective staff and students. An example of a recruitment and retention incentive program that covers both financial and non-financial incentives is the **Rural Health Workforce Incentive Scheme**, as outlined from paragraphs 34 to 41 of my 16 July 2024 statement, which I cover in further detail below at paragraph 74.

40. Opportunities for other incentive programs include:

    a. Expansion of the **NSW Rural Resident Medical Officer Cadetship Program**, as referred to at paragraph 87 of my 16 July 2024 statement. Such programs could be scaled up, including for other disciplines such as nursing and Allied Health. The Cadetship is currently administered by the Rural Doctors Network who have an extensive network in remote, rural, and regional NSW. I understand from the Rural Doctors Network that, subject to receipt of adequate funding, they could expand their administration to cadetships for nursing and Allied Health. Although MOH offers other types of cadetships (for example the Aboriginal Allied Health Cadetship and the Aboriginal Nursing and Midwifery Cadetship), there are advantages in the Rural Doctors Network administering the program due to their rural connections, and independence. The Rural Doctors Network has a long history of administering the program successfully and collecting data to measure the success of the program.

    b. **Transferred Employees Benefits Scheme** (**TEB Scheme**). NSW Ambulance implements the TEB Scheme to provide monetary incentives to permanent employees who are required to relocate as a result of transfer:

        i. to an extremely remote, very remote, remote, far rural or inner rural classified station from a non-classified station
        ii. out of an extremely remote, very remote, remote, far rural or inner rural classified station after two years, or
        iii. to a directed posting outside of the Sydney Metropolitan Area boundary.

    The TEB Scheme provides additional leave and financial assistance to meet the following costs:

i. travel, accommodation and meals when seeking accommodation and commencing duties

ii. school uniforms for dependents

iii. removal and storage, and

iv. purchase and sale of real estate including reimbursement of Stamp Duty (if particular conditions are met).

b. **Housing** - Developing a program similar to one run by the Department of Defence, which builds housing for its employees, particularly in places where people may not want to or cannot settle. This would be different to the current approach which is focused on short-term, localised, modular housing solutions and the leasing of property. In this regard I think there are opportunities for greater centralisation of the leasing of properties by NSW Health and its various entities. There are also opportunities for greater alignment of housing programs across multiple State agencies.

41. There are some practical challenges associated with the running of programs such as the Aboriginal Allied Health Cadetship. For this Cadetship, the current funding limits numbers to 20 per year and prevents any flexibility in the number of cadetships being offered based on eligible students. Cadetships are only offered in locations where a LHD is willing to host a cadet. This, in combination with the large number of Allied Health professions, means that the Cadetships may not be offered in priority areas of need where there is underrepresentation of Aboriginal Workforce, for example podiatry. In addition, there is limited visibility of Aboriginal student enrolments in Allied Health degrees to assist in targeting eligible students. The statewide Program is solely reliant on a single program coordinator position at MOH and there is no succession or continuity planning capacity. Host agencies are not provided any defined financial support to cover their activities for local program management. There is inconsistency between LHDs and SHNs employing graduates at the completion of their Cadetship, which is usually influenced by available vacant FTE and financial limitations at the individual agency level to establish a new role. Additionally, potential cadets may decline Cadetship opportunities due to concerns about:

a. the rising cost of living

b. the request for relocation away from community

c. complex personal, family or community needs

d. financial insecurity, and

e. access to safe and affordable accommodation.

(v) Centralised funding, recruitment, planning and distribution of workers, particularly for regional, rural and remote areas

42. Service delivery and staffing are intrinsically linked. Staffing establishment budgets represent a significant portion of an LHD's overall funding envelope. Chief Executives currently have the ability to prioritise where this funding is directed based on local needs, which can change at short notice. There is a significant risk to overall service delivery if staffing establishment approvals and consequent recruitment activities were centralised entirely, or over-centralised, and moved outside of local control. This is because the connection to local priorities and needs is lost, and additional approval mechanisms that must travel through the centre could ultimately slow processes down.

43. Alternative reforms include updating IT systems, policies, and processes to ensure decisions around staffing establishments and recruitment are automated, intuitive and timely. Work is progressing, led by WPTD in collaboration with eHealth NSW, to give effect to this including enhancements to the HR systems, such as digital checks passport to facilitate easier and faster recruitment and a digital front door to make approvals easier to access.

44. There is potential for MOH to increase its role in co-ordinating the funding, recruitment, planning and distribution of workers, more so than it currently does. This could potentially be done without 'over-centralising' the whole process.

45. Such a system could prioritise allocations to rural areas. However, the system needs to distribute the appropriate amount of people in all areas to avoid shortages in our busiest hospitals, and would result in removing a choice by the workforce as to where they can work which may lead to dissatisfaction. In addition, programs need to factor in exemption requests when people's circumstances change which may require them to move to another location.

46. Furthermore, centralised recruitment cannot fully take into account local skill mix factors. For example, where you have applicants stronger in one skill set over others, local

convenors are best placed to determine which candidates complement the skill sets of existing staff in the team and therefore who should be the preferred candidate.

47. WPTD undertook a detailed current state analysis engagement with all LHDs, agencies and pillars in March and April 2024. This involved having one on one meetings with at least one representative to better understand how workforce planning is currently undertaken. The analysis confirmed the need to increase centralisation of workforce planning. The analysis identified that workforce planning capability is variable across the health system and smaller organisations generally had no workforce planning presence. A system approach was identified as the most appropriate way to spread and share expertise to ensure equitable access to resources. WPTD has co-designed a structure with health organisations and is due to be presented for approval, as per the People and Culture for Future Health project's standing process, by the end of 2024. A central team will help to ensure standardisation, sharing and amplification of evidence-informed practises, and a system-informed view of workforce planning. The governance design specifically includes roles that will take on a facilitation role to build capability in the LHDs and help to ensure more effective implementation of plans.

B. RELIANCE ON TEMPORARY STAFFING ARRANGEMENTS, INCLUDING LOCUMS AND AGENCY STAFF

(i) Succession management

48. There is variability in succession planning across the NSW Health organisations. MOH has commenced reviewing this with a system lens.

49. Skills and knowledge transfer from retiring workforce is a major risk for the health system, particularly in our supply challenged areas. An approach used by other public sector agencies in other jurisdictions has been a workforce replenishment commitment. This uses a system of aligning a new graduate to an existing staff member who has indicated an intention to retire, supernumerary if necessary. SA Water utilised this approach to overcome its supply shortage for engineers by assigning new graduate engineers to retiring staff two years out from the date of separation.

50. This type of strategy would not suit all workforces in NSW Health, but would be particularly beneficial in nursing, midwifery, Allied Health, scientific, technical workforces and corporate back-office functions. These workforce groups may utilise such a strategy at point of graduation or to develop a specialist skill allowing for a better lead time for recruitment to critical roles and facilitate knowledge transfer. My branch has commenced

developing a Succession Planning Framework for the Health system, as part of a Talent Management Strategy, that primarily seeks to implement a systematic and standardised methodology to succession planning to ensure sustainability, stability and resilience in the health workforce across NSW Health. A succession planning model, framework, streamlined standardised process, tools and support resources will be finalised in 2025.

51. A Critical Roles Matrix is also being developed to identify and monitor operational impact, vacancy risk and uniqueness of capabilities required per role. This will allow visibility over potential disruptions to business continuity due to a range of factors including retirement or resignation.

52. Additionally, MOH is scaling up the embedment of a standardised methodology to outline the performance requirements of specific jobs, known as "Success Profiles". Currently in a phased approach, MOH is developing Leadership Success Profiles (**LSPs**) for identified critical roles and executive cohorts. To date, 10 LSPs have been completed including hospital General Manager, Executive Director of Medical Services, Directors of People and Culture, and Clinical Nurse/Midwife Educator.

53. As well, in alignment with our Talent Management approach, WPTD have redeveloped the NSW Health Talent Matrix. This tool has been recently relaunched and is used to track performance and better understand staffing aspiration, engagement, capability, development and development readiness for a promotional or new role. In turn it is used to inform succession including workforce planning by LHDs and SHNs for short-term and long-term staffing arrangements to ensure resource reliability.

(ii) The Locum Vendor Management System

54. MOH procured a Locum Vendor Management system (**VMS**) in 2021. In March 2024, NSW Health mandated the implementation of the VMS across all LHDs and SHNs.

55. At a high level, the VMS provides LHD and facility staff with an online platform for the management of medical locum vacancies. It allows staff to generate requests, advertise and book contingent medical vacancies, vending their request directly to all approved locum agencies. It replaces multiple legacy manual practices and facilitates a streamlined flow of information between facilities, LHDs, MOH and locum suppliers into one system. This in turn provides the MOH and LHDs with vastly improved, real-time visibility over locum usage, spend, and booking practices. It also gives the MOH and LHDs the tools to leverage agency performance.

56. Prior to the 2024 mandate, the use of the system was voluntary. From 2022, Illawarra Shoalhaven LHD, Far West LHD, Mid North Coast LHD and Southern NSW LHD elected to deploy the system. Western NSW LHD had been using a VMS since 2014.

57. LHDs utilising the VMS have seen a reduction in their locum agency fees from an average of 15% down to 12%. Of note, the 15% agency fee statewide totalled in excess of $37 million in the 2022-23 financial year, even this modest early reduction in agency spend alone if replicated statewide, would see a saving of approximately $8 million.

58. The VMS rollout schedule for the remaining LHDs and SHNs is as follows:

    a. Financial year 2024-25: Northern NSW LHD, Nepean Blue Mountains LHD, Hunter New England LHD, Western Sydney LHD, Northern Sydney LHD and South Western Sydney LHD, and

    a. Financial year 2025-26: Murrumbidgee LHD, Sydney LHD, South Eastern Sydney LHD, Central Coast LHD, Sydney Children's Hospitals Network, and Justice Health and Forensic Mental Health Network. The future strategic aims of the VMS include:

        i. tackling NSW Health spend on locum non-specialist doctors through agency fee reduction

        ii. improving the performance of external agencies supplying locums

        iii. further streamline processes, creating efficiencies and reducing duplication

        iv. improving the experience for staff, and

        v. improving the experience for locums, ensuring NSW Health remains an employer of choice for locums.

59. MOH has a staged approach to target agency fee reduction, being:

    a. assisting LHDs to implement a preferred supplier framework within six months of implementation of the VMS, and

    b. creating a curated list of vendors to allow LHDs to negotiate better rates with a subset of preferred agencies (with a target of 11-12% average agency fees from current average of 15%).

60. It is the long-term aim of the rollout, with the benefit now of having the VMS to leverage the buying power of the whole state to further reduce agency fees to achieve a target rate of 10% across all agencies statewide (based on the 2022/23 financial year figures this would represent savings in the order of $13 million annually).

61. WPTD is also exploring the possibility of an AI overlay of the VMS. We are pursuing a dynamic algorithmic intelligence that could review the demand requests received statewide through the VMS on any given day, week or month and based on loading related to rurality, desirability, specialty, skill level required, and other priorities, set an appropriate market rate centrally, and respond to the market centrally. The aim of this would be to better direct the supply of limited resources and to eliminate internal NSW Health competition for locums. We believe this could mediate many of the forces that currently drive-up locum rates.

(iii) An internal locum agency

62. Engaging locums is currently managed at a facility level with each health service competing to source locums in the marketplace, each of them independently negotiating rates and fees with a large number of locum agencies. As outlined above, locum agencies typically charge a 15% fee of the cost of the engagement to source a locum doctor, but rates can be as high as 18%. Locum doctors are a key component of the medical workforce and we are actively seeking to reduce locum costs.

63. In addition to the impact of the implementation of the VMS detailed above, we are exploring the benefits, costs, and risks of disrupting the current market in NSW by establishing an internal business unit within NSW Health to provide recruitment and placement services for locum doctors directly to the NSW Health organisations on a cost recovery basis. There is an opportunity to explore connections and support to services beyond our jurisdiction.

64. The success of any internal agency will be largely reliant on the number of doctors who use its service. For comparison, ten years after the establishment of the analogous NHS Professionals service, which operates as a placement service across the NHS, it commands approximately 25% of the locum market.

65. MOH is exploring the creation of options provided through an internal agency (an 'in-house' service), that would specifically appeal to those who elect to step out of permanent employment to a locum arrangement but who see value in remaining connected to NSW Health.

66. Our initial focus is in developing a value proposition that reflects the key drivers for locum doctors: remuneration, flexibility and autonomy. It will also create a distinct and "special relationship" between the NSW Health in-house service and its locums compared to other doctor/agency relationships by prioritising the continuity of relationships between facilities and locums. This will enable improved continuity of care, provide access to quality assurance activities, and education resources. In addition, it is intended that a medical directorate will ensure skill/role match to improve the locum experience, improve quality of care and offer locums enhanced governance, career pathway and vocational support.

67. Our goal with these locums would be to provide typical agency services but concurrently engage with them to understand their career goals and work to incentivise them back into permanent employment. For those who would be new to NSW Health, the internal agency would prioritise experiences in a range of environments to use their locum experience through the NSW Health in-house agency as a "try before you buy" model.

68. MOH would propose using the internal agency to create a new identity for NSW Health locum doctors to overcome some of the negativity directed towards the current locum community.

69. MOH would seek to work collaboratively with LHDs to create locum opportunities that meet the locum's employment goals (flexibility, new experience, need for time for study etc) while at the same time engendering loyalty and a sense of a "homebase" so they experience being valued by NSW Health, while meeting the clinical needs of our health services.

70. In this way, the internal agency could act as an additional pipeline into permanent employment, and could be uniquely equipped with a range of short-term financial and non-financial incentives. An internal agency would work closely with MOH and be aligned to workforce planning and policy to ensure we support the long-term attraction and retention strategies for medical workforce and avoid any perverse incentives into the locum market.

71. Establishing an internal agency with access to the statewide VMS would offer a system view of locum demand across the State. This offers numerous benefits including the opportunity to maintain a tight rein on locum rates, with any rate rise determined strategically rather than competitively. Additionally, rather than engaging people for a single shift or short run of shifts, the agency could create a single engagement made up

of a series of experiences that utilise the skills of the locum but also maximise the value of the locum to the system. This is only theoretically possible because the agency could see the demand statewide and develop the flexibility to create opportunities and appointments across LHDs and eventually even maybe other jurisdictions.

72. MOH is also considering innovative and experimental models such as:

    a. locum with friends (appointing two or more doctors to a single facility)

    b. packaging clinical placements, for example, a mix of popular metropolitan and hard to fill rural shifts in a single engagement at an overall enhanced rate

    c. fixed term locums on a pathway to permanent employment especially for doctors considering a treechange/seachange with support services to facilitate community engagement, and

    d. grey nomad locums/year abroad locums on a structured engagement across locations in NSW (with or without partnership with other jurisdictions).

73. MOH is aiming to put a set of recommendations to government around the agency, its form and its offerings in April 2025.

C. RECRUITMENT AND RETENTION

(i) Financial incentives

74. As referred to in paragraphs 86 to 89 of my 16 July 2024 statement, NSW Health offers financial incentives in MM 3 – MM 7 locations through the Rural Health Workforce Incentive Scheme. These incentives have been largely successful in lifting retention rates but, for a number of reasons, have been less successful in attracting staff which I discuss further below. The incentives have assisted in addressing pay disparity which exists particularly in relation to interstate jurisdictions. Although staff attrition to those jurisdictions may not have occurred, the incentives have assisted to address the feelings of disparity that affect morale and cause disengagement.

75. The two main reasons that these incentives have not been as successful in attracting new staff to some of the more challenging locations is that after an initial $20,000 sign on incentive there is only a further annual incentive of up to $10,000 available thereafter. This sum, set by the NSW Government's policy and applying to the NSW Health scheme, has not been increased since the early 2000s and is insufficient to attract medical and some allied health professionals. It may be slightly more appealing to nursing staff but is

likely considered too low to attract nursing staff who are not otherwise considering or able to consider a relocation to a regional or rural area. Medical staff below the level of staff specialist is an area where there is dissatisfaction with salary and where we have modelled a shortfall in supply. It is these areas of shortfall we need to be more competitive and focus on offering further incentives.

76. Another reason incentives have been unsuccessful in bolstering recruitment in some areas is that they are geographically limited to MM 3 to MM 7 locations, but there are workforce shortages outside these areas geographically and in particular areas of specialty.

77. My branch is currently looking at the Rural Health Workforce Incentive Scheme, as well as other incentive schemes, to attempt to analyse what attracts people to MM 3 to 7 locations across the workforce. We are:

    a. Determining whether the ability to complete research through partnerships with universities is an incentive to rural and regional doctors, and

    b. Developing a proposal for a pilot program for other financial incentives to attract doctors to MM 3 to MM 7 locations as the current incentives scheme is not successfully utilised for medical recruitment, as only 1.3% of the payments were made to medical practitioners. The proposal would include different payments based on seniority to recruit into hard to fill vacancies, with larger packages for the costs for travel, accommodation, practice development, medical indemnity, college assessments, CPD requirements, and registration expenses.

78. MOH has also designed a policy as part of the Rural Health Workforce Incentive Scheme where there is capacity for individuals who do rural enrichment terms to then be given priority transfer to a vacancy of their choice. However, there needs to be sufficient supply for this system to operate effectively. In the Scheme, transfer incentives provide a health worker who completes 3 years of continuous service in an incentivised position at an MM 6 and MM 7 facility to either return to a substantive position, or priority transfer to a preferred and nominated location. Transfer incentives require prior approval from MOH.

79. There still needs to be a distinction between rural and metropolitan salaries, but more holistically applied across the rural areas. Ideally the system would be designed to pay staff more, the more remote their location. This would require a remote loading for all staff which would then be reflected in a funding subsidy on top of the state efficient price in an LHD's budget. I am not aware of any other jurisdictions with this model and it does

have a number of limitations, including that it locks in higher wages and ignores cost of living pressures for metropolitan staff, both of which would be challenging to address.

80. The framework for the rural incentives is based upon the NSW Government's rural incentive scheme, which applies to all human services and justice agencies. We have been advised that the Government intends to review the incentive scheme. It is unlikely that a standard Government approach will be optimal for NSW Health, and in my view there would need to be a bespoke approach for the medical workforce.

81. The bespoke nature of incentive schemes for medical workforce is not limited to higher amounts of money needing to be offered but includes a redesign of role classifications to attract staff. For example, my branch is considering the employment of Career Medical Officers (**CMOs**) in general hospital-based roles. Although this has been attempted in the past without universal acceptance and only partial success in particular metropolitan areas, this is largely due to such roles being limited to the equivalent of afterhours medical superintendents. It is intended that a new rural generalist classification for CMOs would be designed to address the current need for medical workforce presence at rural facilities.

82. NSW Health has some programs that support junior doctors that have not entered vocational training, including the surgical skills program and the hospital non-specialist program, which are both run by HETI. However, those programs do not provide a direct training pathway into more generalist roles.

83. MOH need to do some further work to develop, govern and centralise a non-vocational training pathway for these generalist doctors which in turn would aid in retention, job satisfaction, skill development and support. This could be coordinated via a state training council with a strong workforce governance and education remit.

84. There is also a need to expand financial incentives beyond geographical boundaries and instead address specialties where there is a particular need. For example, the private sector generally pays in line with NSW Health but will offer higher salaries for in demand specialties, drawing the specialist workforce NSW Health needs.

(ii) Leveraging our Employee Values Proposition (EVP)

85. EVPs articulate why someone would want to work with NSW Health and what we can offer them to have a career in NSW Health. Until recently we had not articulated as a State health system what sets us apart from our competitors. The NSW Health EVP is

"*The team enriching health in millions of ways every day".* This was developed following system wide discussions with our staff, who told us what aspects of NSW Health they are attracted to. The results of those enquiries are that, across the board, staff are attracted to working at NSW Health because of our size and scale and consequently the breadth of roles we can offer. Our unique structure and the opportunity for innovation and mobility across a large system means that, for senior clinicians, they have the ability to work in a structure with more centralised and networked support than the more devolved system in Victoria. For some staff a sense of adventure is a drawcard making roles in rural and remote areas attractive.

86. Whilst mobility is a strong point of attraction for staff, there is a need to streamline the process of moving between LHDs. MOH are trying to design a single staff screening process to work in NSW Health, although a devolved health system does create some barriers to this. The importance of mobility is also important in attracting staff to areas of shortage with the offer of subsequent priority transfer to the location of their choice. Priority transfer arrangements are available as part of the Rural Health Workforce Incentive Scheme, and are negotiated on an individual basis. The Rural Health Workforce Incentive Scheme policy directive provides for agreement between the receiving LHD and the employee to undertake an agreed term, usually two years, in areas where there are workforce challenges. This has to be facilitated centrally by MOH, who instructs the LHD receiving the transfer to take the staff member (potentially when there are no vacancies in the case of nursing), which may impact budget performance. To effect the increased use of mobility and priority transfer provisions, budget availability by way of subsidy for receiving LHDs would assist. Increasing the mobility of staff needs to be offered in combination with incentives, and in my view, will in the long term, help build and strengthen the EVP, and increase attractiveness of placements in hard to fill areas.

87. NSW Health's EVP must be considered alongside other jurisdictions' (or private sector) pay comparisons. In my view, NSW should attempt to be close to parity with other jurisdictions. This, in addition to NSW Health's EVP, may assist in recruitment and retention.

88. What acts as a drawcard will differ across the workforce and NSW Health has to promote its EVP but must do so as part of a larger approach utilising all the available levers.

89. There is scope for NSW Health to explore using an Internal Talent Marketplace (existing in its current Oracle HCM platform) to enable mobility and thereby help to amplify cross-

pollination of good practises. We have commenced a technology scan to better understand the tools that are currently available that may help both standardise workforce planning practises, but also save time on tasks and types of workforce planning analyses that are being duplicated locally. Solutions regarding workforce planning are further discussed below.

(iii) Professional development, training and welfare

90. Part of the EVP and the appeal of an organisation of the size and scale of NSW Health is the ability to offer training and manage welfare of staff. The existence of the HETI and its status as a registered training organisation (**RTO**) is an important point of attraction with learning and development being the number one driver of engagement in NSW Health, as highlighted in our 2023 People Matter Employee Survey (**PMES**). HETI is also a higher education provider under the Training Education Quality and Standards which provides enormous opportunity to expand into delivery of other higher degree programs.

91. Allied Health professionals place significant value in HETI which is largely a result of a very close working relationship between the HETI Allied Health portfolio, MOH and the Directors of Allied Health. Since its inception, HETI has delivered multiple initiatives to support skill development of the Allied Health workforce particularly in areas like:

    a. clinical supervision

    b. professional governance

    c. workplace learning

    d. lymphoedema

    e. capability of Allied Health professional educators, and

    f. building capacity of Allied Health assistants and confidence of allied health professionals in their supervision.

92. Qualification for eligible employment within NSW Health for Allied Health, nursing and midwifery professions occurs via clear undergraduate or post graduate education pathways. Specialist skills and knowledge are acquired on the job and enabled through further internal or external professional development or study. This was covered in previous evidence provided by Jacqueline Dominish in her statement of 5 July 2024.

93. There is an opportunity to develop state training programs that produce standardised micro qualifications and enable local credentialling to ensure consistent acquisition of skills and knowledge across LHDs/SHNs to operationalise new models of care or top of scope practice through our own internal RTO via HETI. This would enable upskilling and recognition of formal qualifications that have been prioritised as in need across NSW Health.

94. A focus on career mentoring, including the identification of career paths for clinicians into executive and non-clinical roles, is an area in which NSW Health can strengthen its professional development offerings.

95. NSW Health offers bespoke mentoring programs aimed at supporting staff development across the different LHDs and Agencies in the Health System. Our existing formal mentoring programs are:

    a. Barranggirra - Skilling for Employment Initiative

    b. eHealth NSW Women's Mentoring Program

    c. HealthShare NSW's Mentoring Community

    d. Bob Fenwick Mentoring Grants Program - for mental health nurses

    e. MentorLink facilitated mentoring program for members of Occupational Therapy Australia, and

    f. Mentoring in Midwifery.

96. Other mentoring programs may be offered by NSW Health agencies locally and mentoring is often a key feature of formal leadership programs.

97. There is an opportunity for MOH to provide stewardship for mentoring programs as part of its approach to succession planning in LHDs and to scale resources. Among other possible development initiatives, NSW Health is currently considering the design and implementation of a development program that would provide career development coaching for identified high potential future executive leaders.

98. The size of NSW Health enables a substantial focus of resources on staff wellbeing. Each NSW Health organisation takes responsibility for supporting the wellbeing of their staff relative to their contexts. MOH has collated more than 150 specific wellbeing support initiatives from across the Health system, and mapped these against identified contributors to wellbeing. These range in nature and include awareness raising materials

in the form of information posters, factsheets and articles, frameworks, programs, and support packages. There is an opportunity to develop a centre-led strategic approach to monitoring wellbeing. Work is being progressed to curate and publish the resources that can be implemented statewide on the Culture and Staff Experience Hub, to reduce duplication of resources and to share leading practice initiatives.

99. NSW Health released the NSW Health Culture and Staff Experience Framework and associated online Hub in September 2024. These provide a contemporary framework for all organisations for establishing positive workplace cultures through focusing attention on behaviours that nurture and support individual and team performance. The NSW Health CORE values have been refreshed through a consultation process with staff and reflect how the values are understood and brought to life in 2024 and beyond. The Framework includes a focus on wellbeing and outlines how staff and leaders can frame their interactions in support, and is reinforced by a resource hub to support teams in understanding and applying the concepts in their workplaces.

100. MOH provides statewide funding to support culture and wellbeing activities by providing Annual Culture and Safety Action funding. In the 2024-25 financial year, there is a strengthened requirement that the funds be used on wellbeing activities in local agency contexts. These will be reported on in 2025 and reviewed with reference to data from the PMES and other local indices (including WHS claims, patient outcomes, overtime, excessive hours, annual leave, tenure, flexible work arrangements, diversity metrics, analysis of demand activity vs supply, culture and wellbeing indicators, complaints/grievances, and EAP rates).

101. MOH has commenced work on establishing a Centre of Excellence for People Analytics. This will create a common approach to undertaking and analysing workforce data across NSW Health. It is anticipated that this will be finalised for implementation in 2025.

102. MOH is leading work to design a culture diagnostic drawing from the annual PMES that will assist in early identification of teams and units of concern. An approach to intervention is being developed by MOH to support addressing areas such as burnout (impacting wellbeing) that are identified through the diagnostic.

103. Maintaining the devolved nature of the NSW Health system has to be balanced against the need for a stronger central role in workforce, both development and planning. Staff do not necessarily need to be based centrally and additional staff may not be required if

there can be a redesign of the People and Culture workforce across the system to develop centres of excellence to implement system level strategy.

(iv) Recruitment strategies to attract talent

104. NSW Health is progressing several initiatives to improve recruitment processes and increase our appeal as an employer of choice. This includes the development of new recruitment collateral to support our recruitment campaigns that aligns to the new EVP. This collateral uses state-wide EVP concepts while also allowing Health Agencies to insert their local content. The first campaign using this collateral was the 2025 Junior Medical Officer (**JMO**) annual recruitment round which commenced in July 2024.

105. During the 2025 JMO recruitment campaign, over 6,000 roles were advertised with more than 100,000 applications received. On average, candidates are submitting 12 applications per year. This recruitment activity is undertaken every year for junior doctors (many of whom are already working within NSW Health) to apply for roles in vocational training and into unaccredited positions.

106. There is opportunity for WPTD to lead a reform of the JMO recruitment process with the overall aim of:

    a. improving the staff experience for both recruiter and applicant by reducing:

        i. the number of applications for candidates, and

        ii. the number of panels our senior clinicians need to sit on, freeing up their clinical time

    b. implementing more formalised networks to facilitate centralised panels

    c. implementing longer length of training contracts.

107. These changes will require additional funding and support to implement, and close work with Medical Colleges to align processes.

108. NSW Health has also made changes to its Careers portal to not only align with the EVP, but to improve the candidate experience by making it more intuitive and easier to apply.

109. Other work being progressed includes changes to processes and systems to standardise and shorten the “time to fill” rates for LHDs (the time for approval to fill to acceptance), improve candidate experience data collection and job advertisement uplifts.

(v) Identifying current in demand service areas

110. How we attract workforce in maldistributed and in demand areas turns on workforce planning. This relates to service demand and design rather than simply filling vacancies, for example, psychologists may not have high vacancies but we know there is increasing service demand.

111. At present, NSW Health focusses too strongly on adapting models of care to the current workforce and the way it currently works, rather than building workforce for delivery of new models of care. Our service planning structure tends to replicate what has previously been done, and then workforce is retrofitted.

112. In my view, NSW Health needs to move away from looking at networking opportunities after developing individual service plans and instead start with a system level networked approach to service. How we identify what workforce is needed and where and how to supply the identified workforce needs greater central oversight to facilitate system visibility and more contemporary service planning. We need to conduct workforce planning not by looking at workforce as a limiting factor but to design Clinical Services Plans in a more connected way between LHDs and consider the new models of care available and the workforce that might be created to deliver them. Although MOH has expectations that the LHDs will demonstrate networking in their Clinical Services Plans, greater centralisation of this function would ensure that we standardise models of care, capture innovation opportunities and look at supply of workforce to meet these opportunities, rather than determining that existing workforce prevents these opportunities from being considered.

(vi) Workforce pipeline

113. As discussed above, it is after the completion of planning work in the form of a Clinical Services Plans when the system tends to look at what is needed in terms of workforce and this can be a limiting rather than enabling way of planning service delivery. To strengthen the system wide and networked planning of clinical services, we need to create a pipeline of workforce to meet the needs identified in that planning. This needs to occur from students through to specialists, but at the moment the pipeline is heavily dependent on factors outside NSW Health's control and consequently there is a degree of reactive rather than proactive planning, particularly in relation to graduates where CSP placements are controlled by the Commonwealth and the universities.

114. The role of universities is important, particularly in the ability to offer online learning to students who may otherwise face a barrier to entry into a healthcare profession and this should be preserved. There is, however, a need to consider what further training can be offered through NSW Health in the area of nursing, to ensure that nursing staff are job ready at graduation. Although we have had success in employing nursing students as Assistants in Nursing (**AINs**) while they gain their formal qualification as RNs, we need to consider whether this is the ideal model. There may be greater benefit to the system if we create RN training roles for student nurses, rather than employ them as AINs. This model is also likely to be attractive to private hospitals and would allow both the private and public health systems to be more connected to education providers.

115. NSW Health has commenced a scholarship scheme with the Shalom College at UNSW to attract rural Aboriginal high school students into a medical degree. The program aims to target Aboriginal students who otherwise would not be able to attend university if it was not for financial assistance to support costs associated with attending and residing at University in Sydney. The student agrees to return to their rural area to practice at the conclusion of their study. All costs associated with accommodation and meals during study while residing in the college are paid through the scholarship. One Aboriginal medical student from the Murrumbidgee region is currently supported by MOH.

116. The cost of such a program limits the expansion of the program or application to other areas such as nursing or Allied Health students. Whilst this program is not available to other health professions, as mentioned above, there is a suite of scholarships, incentives and cadetships available.

117. Attracting a diverse workforce may be assisted by expanding cadetships to target other priority population groups including individuals with a disability or refugee groups.

118. Given that the levers that control university places rest with the Commonwealth, and collaboration with the Commonwealth is ongoing but not yet be fruitful, it may be necessary to consider a more radical approach. This could include expansion of bonded scholarships to regional universities and requiring students to remain in those regional areas on graduation, although there are some practical challenges at times associated with graduating students and person and family circumstances that interfere with the ability for them to work in regional and rural roles. NSW Health could consider running degree level qualification programs that satisfy registration requirements through HETI for nursing students, although this is less likely to be a viable option for allied health given the smaller volume of students. The tertiary degree program for nurses has been an

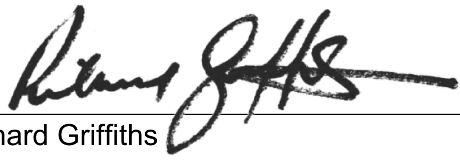
effective way of building the professionalism of nursing careers, however, there is no reason why that degree must be delivered through a university. Appropriate accreditation from the Australian Nursing and Midwifery Accreditation Council would be required, and the delivery would naturally incur significant cost, particularly if rural delivery is contemplated. However, the control over cohort size and the ability to train and funnel graduates to areas of need is very attractive.

D. TRANSITIONING TO A SKILLS-BASED WORKFORCE PLANNING MODEL

119. The health system would benefit from transitioning away from discipline supply-based workforce planning to skills-based workforce planning, and my branch is progressing work to begin this transition. The goal of this planning is to model skills, capabilities and tasks against clinical demand to gain a better picture of the actual skills needed to provide clinical services, particularly as there is significant commonality in scopes of practice, curricula and aptitude across clinical disciplines. This process will allow us to map the workforce against clinical demand more holistically. It will also allow multidisciplinary and transdisciplinary models of care to be better mapped out and implemented. In areas where certain workforces are in short supply, a clinical model utilising the existing available workforce skill can be safely developed. The move to skills-based planning is expected to identify care models using a more efficient level of FTE workforce as practice opportunities across currently more restricted discipline scopes should become available.

120. This planning is also seeking to identify inefficiencies associated with the use of mandated practitioner ratios, which often lock the system into ratios of high cost, high scope practitioners and rigid 'turf wars'. The current mandated levels of RNs in certain units, for example, inhibits innovation and results in the system being unable to insert AINs and Enrolled Nurses into the clinical services models, which results in RNs spending significant proportions of shifts operating at the bottom of their scope of practice. This also prevents important career pathways and intradisciplinary succession strategies being utilised to bring nurses into RN practice, and is, in my view, not in the interest of the existing RN workforce.

121. A skills-based workforce planning methodology is currently being piloted in Health Infrastructure, with the intention to widen a trial following the initial pilot which is due to report around July 2025. The implementation of full skills-based workforce planning will require the engagement of a significant number of stakeholders, including education institutions, medical colleges, and industrial associations.



Richard Griffiths

Louis Yuill

8 October 2024

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