New South Wales

Special Commission of Inquiry into Healthcare Funding

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Name: Cancer Services, South Western Sydney Local Health District

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NSW Government
Special Commission of Inquiry into Healthcare Funding
South West Sydney LHD- Cancer Services.

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A.	The funding of health services provided in NSW and how the funding can most effectively support the safe delivery of high quality, timely, equitable and accessible patient-centred care and health services to the people of NSW, now and into the future	There needs to be more equitable funding distribution of services per capita, both inpatient and outpatient across the state. For example, several reports have shown that the concentration of inpatient beds (public and private) per capita population are significantly reduced in the west and south-west of Sydney, where there are higher disease burdens and yet the funding models fail to adequately address this. This is why these hospitals feature more regularly when reporting high levels of bed block. And yet, when these periods occur the Ministry seem to imply it's our models of care rather than the maldistribution of beds. This is exacerbated when access to bulk-billing GPs without having to wait long periods is very challenging, and hence patients report to ED as a "free" alternative. The solution to this is providing greater outpatient resources so that patients can be seen in a timely fashion and their problems dealt with rather than crisis management as patients' health has not been adequately addressed in a timely fashion. The special needs of CALD population and refugee population as well as the non-English speaking patient population to be strongly included in the decision making when these decisions are made. Some of these populations have high disease burden which may need extra funding to achieve similar outcomes as rest of the population. The inpatient stay for the low socioeconomic group, CALD, Refugee population is usually longer than rest of the population and hence their social and cultural circumstances need to be considered when the funding decisions are made. Greater numbers of allied health staffing on the wards would also reduce admission durations We need to fix the NDIS mess that results in prolonged admissions with no alternative discharge plans other than waiting for approval. The health budget needs to better support innovation. Most budgets are set by the CEO/CFO based on historical expenditure (i.e.

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	retrospective and reactive to problems). This leaves very little investment in new innovative models of care that would reduce or minimise emergency presentations. Most outpatient services provide ED avoidance strategies, especially when we also can use electronic Patient Reported Outcome Measures [PROM] to assess patient symptom burden prior to a crisis occurring. However, the budgetary focus is more and more about emergency and surgical waiting lists and access to inpatient care with outpatient services less well funded and prone to closures as there is inadequate capacity especially during periods of leave. SWSLHD Cancer Services have successfully shown a reduction in admission for patients using electronic PROMs and yet the implementation has struggled due to inadequate funding to make this "usual care", relying on contract funding rather than permanent funding. More funding needs to be made available to develop clinical dashboards that assess care equity, preferably in near real-time. More community health treatment centres should be considered for funding so that the hospitals are mainly utilised for acute medical issues and all chronic care etc. is done via these community treatment centres The division between state and federal funding creates an artificial barrier and leads to unnecessary paper work for the clinicians adding more workload to their already busy schedules. An example of current inequity is the Cancer Genetics service in SWSLHD. It receives over 700 new referrals annually and runs a high risk surveillance clinic for 50 patients with 0.6 FTE staff specialist, 2 FTE associate genetic counsellors and 1 FTE administrative staff. Since the last enhancement the waiting list has grown from 3 to 7 months.
B. The existing governance and accountability structure of NSW Health, including:	

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i. the balance between central oversight and locally devolved decision making (including the current operating model of Local Health Districts);	Sometimes structures are too rigid. Look for best practice models and share across the State. Agree there needs to be accountability for financial resources without onerous reporting. Many Clinical Directors of a service feel they have very little say on whether funding should be altered. The only strategy was to "bid" against other departments for priority funding. This meant that in a hospital with lots of priorities it would be rare to receive the funding requested even when service demand alone grew 10% during the bidding process. The Heads of Department need greater say in what the service funding model should look like. There is also limited district wide approach to service provision and allocation of enhancements, many senior staff see themselves as advocating for their hospital not the LHD and we are seeing increasing barriers put up where rationing of services based on a patients LGA limiting care that patients require. Review of delegation manual to provide more responsibility and accountability at local level. There is maldistribution of resources across and within the LHDs, which sit at historic funding and do not grow with the needs of the district e.g., Liverpool Hospital is saturated at its capacity and can no longer increase its efficiency or workload so can't increase its activity based funding. When a new service opens at Campbelltown to decant this work from Liverpool it also is inadequately funded and the maldistribution is perpetuated. The complexity of care in looking after the patients with non-English speaking background, complex social structures, poor health literacy and socioeconomic disadvantage are not captured into the funding needs.
ii. the engagement and involvement of local communities in health service development and delivery;	This is fundamental to getting it right and should not be tokenistic however often funding made available and time is against us in doing genuine consultation. Also choosing best community engagement can be challenging particularly for vulnerable groups and CALD populations.

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	Funding should be included for use of interpreters etc. for these consultations and engagements. Educating GPs, a large proportion of whom are overseas trained doctors and do not understand the public health system as locally trained doctors. Seamless transition of care should also occur from hospital to community. Increased use of the *HealthPathway* model developed by the South Western Sydney PHN and SWSLHD to support GPs to manage and refer patients to Cancer Services
iii. how governance structures can support efficient implementation of state-wide reform programs and a balance of system and local level needs and priorities;	The existence of eHealth NSW was designed to provide state-wide leadership on the planning, implementation and support of ICT and digital capabilities across NSW's public health system. They are accountable for eHealth across the NSW health system. With significant financial investment from NSW Government, it is perplexing that the Local health districts are then expected to pay eHealth NSW for the delivery of projects that will improve the workforce and/or the patient experience in the health system. And in most cases, the costs are prohibitive: i. To create a ServiceNow form to improve the request for cancer EMR access or data extraction was quoted to be $5000 ii. Projects that will clearly lead to improved patient outcomes require a security assessment and a penetration test that could cost up to $70,000, with no alternative available to NSW public health departments. There is no/minimal additional funding provided to the Local Health districts to account for the costs that will come from engaging eHealth NSW to innovate and implement tools that will improve workforce and/or the patient experience. The "Cloud first" policy failed to recognise that LHD's do not have the budget to cover the costs to implement systems in the cloud and to pay for the ongoing costs. eHealth have quoted the LHDs "at market rate" costs instead of "at-cost rates".

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	Does eHealth's financial model include making a profit from the LHDs that are struggling to find and fund staff? The investment in eHealth NSW is also concerning since many projects are undertaken by contractors who are paid extremely high rates, much higher than the award rates for NSW Health IT staff and health managers. This then raises the question of where the funding is going if the people working on projects are not employees of eHealth NSW; funding that is diverted away from NSW health system. A similar model exists from NSW Pathology where they are charging LHDs for work done, particularly in clinical trials research. For sub speciality services NSW health should fund centres of excellence for access for patients across the state e.g., comprehensive patch testing at Liverpool Hospital, Mohs surgery in a public hospital, thalassaemia and transfusion service where the bulk of adult patients live in SWSLHD.
iv. the impact of privatisation and outsourcing on the delivery of health services and health outcomes to the people of NSW;	Monitoring required to ensure value for money and rigour in the contracts for same. Need to look for the "why" services have been privatised or outsourced to genuinely look at local funding gaps, staffing gaps, niche service that local service cannot provide or expensive services that could be delivered more cheaply locally. All outsourcing must include KPIs and reporting to ensure outcomes and safety for patients. This is particularly true in rural /remote areas that otherwise would be without some services Public Private Partnerships (PPP) need to be addressed at a federal and state level. We need frameworks and legal consultation. Legislation around privacy, confidentiality, information sharing, consent processes are complex and should not be done by LHDs and individual departments which is inefficient and costly. For a PPP to be effective, information sharing should be mandatory even for the private sector because we know that patients, even the private

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	ones, are likely to attend emergency departments in the public health system and we have no information on them. In haematology and oncology, without knowing with accuracy what chemotherapy a patient has had or what radiation doses to what areas of the body a patient has had, we could inadvertently cause harm to our patients. The state and federal governments have to find a way to allow information sharing using the platforms that millions of dollars has been poured into i.e. HealtheNet and My health record. Public private partnerships are not a blanket solution for all of NSW. The government needs to look at the demographic of the patients in the various LHDs around the state to determine where to focus these efforts for maximum gain otherwise, we waste time and effort. In terms of radiation oncology there have been challenges related to the sudden proliferation of private oncology services. Some private services have been established well whereas others have not considered the models of care required for a comprehensive suite of services for patients including no ready access to inpatient beds when required and little or no access to care co-ordination and allied health services. This is bad for patient care. In addition, information regarding the patient care has become more fragmented. In radiation oncology, the Department of Statewide services used to strategically plan the distribution of radiation oncology services. However, this no longer seems to be the case with a very large upswing in the provision of private radiation oncology services. While there should always be the options available for patients to access both public and private this upswing has resulted in challenges for public radiation oncology services, which partly rely on patient activity to fund ongoing research efforts. The risk will be a reduction in academic radiation oncology, similar to what has occurred with the widespread privatisation of radiology services, with little academic radiology practice going on. This is ultimately bad for patient care as

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	innovation and clinical trials activity have both been shown to improve patient outcomes. The unco-ordinated proliferation of private radiation oncology services, occasionally with even 3 providers within the same postcode, has resulted in a demand on recruitment of radiation therapy and medical physics staff that exceeds the current supply of graduates and a number of public radiation oncology departments have been unsuccessful in recruitment. Perversely this will lead to waiting lists for care in public facilities which then further encourages private use. The planning of these services needs much greater co-ordination and consideration of the needs of patients for both high-quality public and private oncology services. The investment into public radiation oncology departments to keep up with demand has been lacking and this would be a shame for it to deteriorate further. Further engagement with private providers to inform planning of resources for public hospitals to optimise efficiencies. E.g., 3 PET machines in Campbelltown in near future – the public hospital PET machine is not funded for staffing and potentially will be redundant The limitation of private providers in SWSLHD places an unequal burden on already stretched public services. With respect to dermatology access affordability for private dermatology services in the district are highly constrained. Currently, there are 0.86 FTE dermatologists per 100,000 thousand population in South West Sydney against approximately 6.0 FTE per 100,000 in the Eastern suburbs of Sydney. To meet the state average of 2.1 FTE dermatologists, currently need 22.0 FTE dermatologists to service the population of 1.1 million people in the district. Currently there is one private Cancer Genetics specialist provider in Sydney, with their practice located in Sydney city and northern Sydney area. As such, this is not readily accessible for face to face appointments for residents of SWSLHD. The out of pocket costs associated with attending a private clinic also mean that this has little impact

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	on wait times for the Cancer Genetics clinic at Liverpool Hospital. Currently, there is availability for limited initiation of germline genetic testing by non-genetics specialists (mainstream genetic testing) which is guided by MBS eligibility criteria. These item numbers are theoretically available for use by specialists in the private sector, but in practice, we have seen little evidence of this occurring in SWSLHD.
v. how governance structures can support a sustainable workforce and delivery of high quality, timely, equitable and accessible patient-centred care to improve the health of the NSW population;	Governance is key to any improvement in outcomes, from our perspective there is little or no co-ordination between the state and the universities regarding placement numbers for undergraduates. This is especially problematic currently in radiation therapy, ever since Sydney University closed their programme, meaning that Newcastle Uni is the only undergraduate opportunity in NSW. This needs to be fixed Provision of flexible working options – use of temporary locums to cover leave to preserve staff wellbeing and ensure a constant service. The governance should be centralised with leaves, on call rosters, PMR etc., being managed by the director of the networked clinical services More involvement of the consumers, treating medical and nursing team will give them more empowerment that the local needs are being heard and appropriate action is being taken as per the needs of the patients
C. The way NSW Health funds health services delivered in public hospitals and community settings, and the extent to which this allocation of resources supports or obstructs access to preventative and community health initiatives and overall optimal health outcomes for all people across NSW;	The current focus for budget in NSW remains solving ED waiting times. But attempting to fix this solely with more beds or “more efficient” models of care will not work without investing in the services required to reduce ED demand such as availability of outpatient services including allied health and all major medical specialties. There has been little investment in outpatient during my time in SWSLHD. Sub speciality centre of excellence in the state will improve the quality-of-care patients receive such as for low volume cancers.

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	Hospital funding for staff specialists and trainees should respond to current and projected needs of the district. This need should include population growth but also requirements of increased scope of service e.g., Paediatric dermatology in South Western Syndey Local Health district has currently 10,000 babies born annually, further given a large population of first generation immigrants with a higher incidence of eczema in this population. The patients from lower economics status have poor health outcomes. SWSLHD also has a large number of trade persons and other outdoor jobs who have a high risk of skin cancers form the cumulative sun exposure. The identification of a hereditary cancer predisposition syndrome provides information to primary and community health initiatives to improve health outcomes for individuals and families at increased risk, through education regarding cancer risks and strategies to prevent cancer or assist in early detection through screening. Restricting timely access to cancer genetics services through long waitlists and/or centralisation of services to selected hospitals (in the case of SWSLHD, to Liverpool Hospital) is therefore not in line with achieving optimal health outcomes in this local health district. The SWSLHD Cancer Genetics is relatively less well resourced (in terms of staffing) compared with other familial cancer clinics in Sydney, which works to exacerbate the health disparities between SWS and other LHDs. Better funding of GP practices and models to reduce ED presentations to restrict to complex, urgent cases Currently much of the focus is on achieving the ED targets for admission/review. Hence the focus is on creating more acute bed space and discharging patients etc. The focus needs to shift to whole of patient care/health where the acute hospital settings, outpatient settings, community settings for care are also managed. 50% of cancer patients in SWSLHD do not start chemotherapy

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	within national benchmark standards, so access to care needs to be considered for areas other than ED and elective surgery. Consultative services such as palliative care need to be considered as consult services do not attract funding .Biggest obstruction is the State and Commonwealth divide which effects services patients may be able to access, medications and equipment.
D. Strategies available to NSW Health to address escalating costs, limit wastage, minimise overservicing and identify gaps or areas of improvement in financial management and proposed recommendations to enhance accountability and efficiency;	Service /facility efficiencies in discharge planning/ discharge/transport. Often many inefficiencies that have patients waiting to get home etc We would recommend investment in prevention and early detection, supporting value-based care of radiotherapy, utilising generic drugs, negotiating drug prices using a healthshare platform similar to negotiating for all radiotherapy departments, using more of telemedicine and advocacy for policy changes that addressed the high costs areas Regular review of inpatient tests requested, restricting ordering of certain imaging to certain providers (e.g., PET scan) to reduce significant costs where practitioners are not adopting or implementing models to eliminate Low Value Care. Education and training of the local community – community leaders, GPs, nurses and eventually focus on preventative strategies to improve the health of the population. The cost of germline genetic testing has decreased markedly over recent years. Improvements in technology allowing multiple simultaneous gene testing (panel, exome or genome) have enhanced the cost efficiency. In some circumstances, improving access to genetic assessment and testing has the capacity to provide more accurate cancer risk assessment. Individuals with an identifiable hereditary cancer syndrome can access evidence based screening with the capacity to diagnosed cancer at earlier state or prevent cancer. Both of these strategies

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	can reduce the overall cost to the health system and treatment costs are minimised. There are limitations in the custom germline genetic panels available through NSW Health Pathology.
E. Opportunities to improve NSW Health procurement process and practice, to enhance support for operational decision-making, service planning and delivery of quality and timely health care, including consideration of supply chain disruptions;	Medication access and drugs no longer being manufactured and sourcing new supply chains of critical medicines i.e. oral morphine liquid Substantial time is wasted on extensive paperwork, chasing signatures, finding additional funding. A cost analysis on the process will reveal that thousands of dollars are wasted per day across the health system which places even more strain because the staff, in many cases, are taken away from their BAU activities. Just like there are KPIs around recruitment times, there should be KPIs around other aspects of approval processes. Allow for more competitive process with less reliance on "monopoly" providers – although unavoidable in some cases. e.g., Slade pharmacy – investigate whether potential for self-compounding. Use of LHD wide agreements – currently different agreements for different hospitals with discounts given to some, not others. Over the past few years, there have been increasing delays in the turnaround time for genetic test results to be made available. The outcome of uncertain and lengthening turnaround times for tests from a clinical perspective is Time wasted chasing up results; Patient anxiety whilst awaiting several months for results; expiration of referrals whilst awaiting genetic test results with unnecessary time spent by patients seeking out new referrals and unnecessary costs to the health service subsidising appointments relating purely to obtaining referral letters. Advice from the NSW Health Pathology sites will be able to clarify the causes for and potential solutions to these issues, which certainly recently

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	have also included supply chain disruptions in addition to other causes.
F. The current capacity and capability of the NSW Health workforce to meet the current needs of patients and staff, and its sustainability to meet future demands and deliver efficient, equitable and effective health services, including:	Workforce reviews required for specific craft groups/disciplines and using population methodology projecting future needs of FTE We feel there needs to be more allied health and nursing staff enhancement to meet the demands. In our opinion there is more than adequate specialists being trained currently. This should reduce the reliance of the more expensive doctor led clinics and implement models of care with task transfer to equally well trained nursing and AH staff.
i. the distribution of health workers in NSW;	Reviewing FTE against population based approach ,including future forecasting population and benchmarking across and within LHDs. There is a need to address the insufficient health workforce in regional centres. The current dermatology workforce in SWSLHD is significantly under resourced, hyper fractionated at 0.1-0.2 FTE. There is a clear maldistribution of the dermatology workforce in NSW as the funding sits at historical levels while the population growth is highest in SWSLHD due to increasing cost of living pressures The workforce planning should be based on current and projected population of the area and special needs with respect to the diversity of the demographics e.g. Cultural and linguistic diversity , socio economic disadvantage , health co morbidities The Cancer Genetics clinic at Liverpool Hospital, SWSLHD, is one of the most poorly resourced familial cancer services in NSW. It receives over 700 new patient referrals each year in addition to managing a high risk surveillance clinic for 50 women at high genetic risk of breast/ovarian cancer. It is staffed by 0.6 FTE staff specialist, 2 FTE associate genetic counsellors and 1 FTE administrative staff. The number of referrals has more than doubled from 2017 to 2023, and increased by 22% since 2020, which is when the last staffing enhancement (increase in staff

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	specialist fraction from 0.3 to 0.6 FTE) occurred. The number of women accessing the high risk clinic has more than doubled since 2020. The lengthening waitlist times impact on the service's ability to deliver timely care to referred patients and families. The distribution of health workers in the familial cancer field is not even based on the populations serviced within NSW and exacerbates inequities in health care for SWSLHD residents compared to other LHDs. This needs a detailed review as many health care workers in south west Sydney are aware that the patient to doctor ratio in SWSLHD is significantly different to other inner city LHDs. This is one area the equity needs to be looked into and actioned The health care workers positions need to be funded as per the local need rather than as per the current process of funding as per the LHD financial health
ii. an examination of existing skills shortages;	We need to understand the 'why' (linked to training numbers, new grad job numbers, overseas trained staff who cannot register) We have existing skill shortage of radiation therapists across NSW (and Australia), and have attempted to make representation with the Ministry regarding engagement with University to provide an undergraduate or post-graduate program within Sydney to mitigate this shortage Investment in the upskilling of the specialist and generalist doctors is required for skin cancer management. Funding and placement of International Medical Graduates can be a potential speedy solution. Equalising the grading across all LHD positions would improve staff retention. For example, genetic counsellors in SWSLHD are usually recruited as Level 1 counsellors that have just completed their Masters of Genetic Counselling Degrees. They require a high degree of training and cannot work independently. By contrast

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	other Cancer Genetics (Familial or Hereditary Cancer) services frequently have long term level 3 or above Certified Genetic Counsellors. Staff will leave for better paid positions in other LHDs There is significant shortage of chemotherapy accredited nursing staff across SWSLHD. With more private cancer centres coming into the area, this problem will be further heightened. The need for senior skilled nursing staff for haematology is significant
iii. evaluating financial and non-financial factors impacting on the retention and attraction of staff;	More workforce strategies that take staff feedback seriously, need exit interview data to limit future loss of staff. Staff in health generally do not want pay incentives, they want equity of staffing so they have the same level of support that other staff have in other LHD's- admin, nursing and allied health support are examples. Enhancements to services has been lacking despite the NSW government being aware that the patient numbers and occasions of services is rapidly increasing in NSW health. The ABF model is either not highlighting this growth or it is and NSW Health and government is not asking the question of how the system is coping. Reducing lengths of stays is not going to work for chronically ill patients and the risk of re-admission is high. The staff are overworked and at risk of burnout. Many staff across NSW are doing more, seeing more patients, working (unpaid/invisible) over-time to get through the workload and this will not be evident in the activity data. And the staff do this because they care about their patients. In some cases, private practice trust funds have been funding extra positions to keep up with the demand and this is not a sustainable solution. Applying for grants to bolster resources to do innovative work for NSW patients is time consuming, competitive and is also non-sustainable as the ability to embed and upscale often needs staff enhancements which do not follow. It also does not provide staff with job security and leads to high turnaround of employees which is disruptive to a service.

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	Staff retention is a major problem also due to the lack of flexibility in work arrangements in the public health system and the wage gap between the different states for the same/similar roles. In a socioeconomically disadvantaged population the affordability of accessing private medical services for chronic diseases is constrained which pushes more work to public facilities of EDs. Affordability and the fee structure also determines desirability of a specialist working in an area in private. NSW has the lowest wage structure in health care, highest cost of living including accommodation and transport not to add travel times of at least an hour each way resulting in migration of staff interstate to overcome these challenges. Significant incentives need to be introduced to recruit and retain staff. Without senior workforce there can be a lack of on site support; high workload for early career staff; minimal time within work hours to consider ongoing training career development requirements and less opportunity for research SWSLHD may not be preferred for staff living more distantly from the workplace, who then seek opportunities closer to their home. We can retain medical physicists and radiation oncologist but we are short of ability and financial incentives to retain radiation therapists The workload is significant for burnout of health care workers in SWSLHD and this needs to be balanced
iv. existing employment standards;	The dermatology work force in SWSLHD is highly fractionated , at 0.1-0.2FTE reducing engagement and most staff working longer hours to reduce wait lists The financial remuneration is same for a position in NSW Health. In SWSLHD for the same remuneration, a health care worker would be doing significantly more than their peer in other

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	LHDs. The work load needs to be considered in the funding structure
v. the role and scope of workforce accreditation and registration;	As per ii some processes for medicine are long and complex The accreditation process is quite onerous and time consuming, this can sometimes act as a deterrent to anyone but the most motivated person.
vi. the skill mix, distribution and scope of practice of the health workforce;	In Gynaecological Oncology and Head and Neck Cancer surgery, there is absence of expertise placement and skill mix across the state with surgeons working at Lifehouse, and not wanting to work out of central Sydney. The majority of nurse care coordinators in SWSLHD, a standard of cancer care, are funded by philanthropy [McGrath and Prostate Cancer Foundation] with risks of retention as these are short term contracts if doubt of future reliable funding.
vii. the use of locums, Visiting Medical Officers, agency staff and other temporary staff arrangements;	Guidelines and rules required to ensure not used as easier option but for genuine service gaps such as prolonged sick, long service and parental leave. The amount of money spent of locums could easily be transferred into permanent salary and wages for some departments. The mix of VMO and Staff specialists (in Radiation Oncology) don't work quite well in regional NSW. Provide incentives to partner with rural services for trainee secondments to increase likelihood of long term rural placements This is unavoidable due to the long drawn process of recruitment where approval for recruitment is required even against a resignation creating further stress in terms of work load management.
viii. the relationship between NSW Health agencies and medical practitioners;	NSW health needs to be engaging with the doctors on the coalface for input into policies that shape funding.

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	Upscaling worthy and award winning projects coming out of the ACI or CEC across LHDs would be important to improve efficiencies or patient care state wide, not just in the one LHD that implemented the project. The issue of eHealth charging LHDs for work that LHDs are unable to tender for is wasteful.
ix. opportunities for an expanded scope of practice for paramedics, community and allied health workers, nurses and/or midwives;	There is a need to enhance and increase the role of Nurse Practitioners in improving patient care, safety and efficiency. Some examples include; run a follow up or survivorship clinic in parallel or in conjunction with specialist clinic improving new patients being seen in a timely manner (less than 2 weeks from referral); assess unwell patients (ED bypass service); facilitation of mainstream germline genetic testing pathways to assist in timely identification and testing by non-genetics specialists; assist in coordination of the high risk surveillance clinic, which is currently managed by the staff specialist Better utilisation and upskilling of the allied work force to deliver meaningful education , reassurance at first point of care and ingoing reiteration for management of chronic diseases will likely improve long term outcomes
x. the role of multi-disciplinary community health services in meeting current and future demand and reducing pressure on the hospital system;	Explore need to provide extended hours services and home visiting particularly with declining GP availability 7 days per week; implementing a virtual care nurse led model for advice should limit presentations to ED or readmission rates. Without an after hours GP service the default is to present to ED. SWSLHD has been working with local PHN to share the ongoing FU between GP and specialists such as a shared care model with community health services (e.g., breast cancer follow/up) There is a need to deliver culturally sensitive, appropriate, at home care for vulnerable communities of the First Nations people and first generation immigrants with limited mobility and language skills

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	We think it is important to have discussions with the community and look at reducing the hospital presentations and preventative health should be a major focus
xi. opportunities and quality of care outcomes in maintaining direct employment arrangements with health workers;	Nurse practitioners will be a huge help in NSW Health. Victoria health has huge number of nurse practitioners. We do not have any nurse practitioners in cancer services and this is a huge gap to fill
G. Current education and training programs for specialist clinicians and their sustainability to meet future needs, including:	For SWSLHD this is perhaps the greatest challenge
i. placements;	Need to also look at specialist nursing and allied health and access to funding training, conferences etc. Drs have TESL, others have self funded or perhaps scholarship support if lucky We currently don't have positions to offer Fellowship within Radiation Oncology. Most departments use their private practice trust funds to support the Fellowship program which is unsuitable. Trainee placements are determined by the NSW faculty and the hospital has no say in the selection and placement of trainees in some specialties. Placements should consider needs of the service and potential workforce solutions in addition to training needs of an individual. It is a difficult balance between trainee autonomy selection and providing service to populations within NSW. In general the well resourced LHDs with supernumerary fellow positions fill their trainee component first whilst outer metro, rural and remote have to cover vacancies. A full stocktake of all registrar and staff specialist positions based on the population of an LHD needs to be taken to address this inequity.
ii. the way training is offered and overseen (including for internationally trained specialists);	The International Medical Graduate recruitment is burdensome with too many hoops to jump through particularly establishing an area of need. In general the training provided in NSW Health for medical specialists is excellent and admired by rest of the world, it is the appropriate

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	distribution of these training roles that needs addressing.
iii. how colleges support and respond to escalating community demand for services;	Colleges do not see themselves as solution providers for work force issues as Fellows of Colleges cannot be forced to work in an area of need [AON]. However proper selection and placement of trainees in an AON can help address the maldistribution of the workforce to select and train registrars from the area so that they can return to work in the area . As Cancer Genetics crosses 2 current specialities (traditionally more closely aligned with Clinical Genetics although the training profile is changing over time), and is a relatively small specialty in terms of number of specialists, it has been hard to advocate for a recognised training pathway that addresses the needs for Cancer Genetics as a specific and growing area of need.
iv. the engagement between medical colleges and local health districts and speciality health networks;	Limited engagement by colleges with LHD and unrealistic expectations re training requirements and operational requirements. Better “real world” engagement required by colleges to prepare trainees for working environment. Some accreditation reports seem to be at the whim and biases of the assessors as we are aware of other sites not receiving negative recommendations for identical work conditions. This needs to be improved as the College of Dermatologists has a national selection process and is not always aware of needs of a district, the number of training positions they offer are not matching demand. Training opportunities are limited to the 4 largest Cancer Genetics in Sydney. There are 2 x 1.0 FTE positions for advanced trainees in Cancer Genetics in NSW, and these are shared between Prince of Wales Hospital, Westmead Hospital, Royal Prince Alfred Hospital and Royal North Shore Hospital. NSW Health need to fund more positions and the College need to accredit more positions.

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v. how barriers to workforce expansion can be addressed to increase the supply, accessibility and affordability of specialist clinical services in healthcare workers in NSW;	Benchmarking across all LHDs based on the workforce supply needed for a population also taking into account some loading needed for low volume rare quaternary services. Looking at all staff employed at all levels to provide transparency is crucial to identifying maldistribution of staffing especially as the more established hospitals have had historical funding when they were providing services for WSLHD and SWSLHD. The investment in funding for JMOs and registrars from the area to train in the area to meet the unique health needs of the demographic and feel confident to return to the area to work. To address barriers to workforce expansion to achieve parity requires funding. Additional staffing will allow accessibility to specialist services and improve access to affordable specialist services within the public health system to allow implementation of the SWSLHD locally endorsed *One Service Multiple Sites* Model of Care. The main barrier is financial and support from the LHD to look at the need for new positions and expansion of clinical services where the need is. This requires input from the 9 LHD Clinical Directors to advice on enhancement priorities rather than which facility director can influence a local general manager or a local Clinical Council.
H. New models of care and technical and clinical innovations to improve health outcomes for the people of NSW, including but not limited to technical and clinical innovation, changes to scope of practice, workforce innovation, and funding innovation	In a speciality like haematology, intensive treatments are often performed as an inpatient and patients spend a lot of time in the hospital. If there was funding for outpatient management 7 days a week the majority of these patients can spend time at their own home and come for review frequently in outpatient settings. However the funding for this service has not been a priority for the health services as inpatients are the main priority. Patient care as a whole need to be the main focus when the funding is decided.