New South Wales

Special Commission of Inquiry into Healthcare Funding

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Sydney Local Health District (SLHD) is located in the centre and inner west of Sydney and is made up of the Local Government Areas of the City of Sydney (part), Inner West Council, Canterbury-Bankstown (part), Canada Bay, Burwood and Strathfield. It covers a geographic area of approximately 126 square kilometres. With around 14,000 staff, our District is responsible for the health and wellbeing of more than 740,000 people living within our boundaries, as well as more than million people who come into our District each day to work, study and visit, and many more that travel from rural and remote parts of NSW and Australia to receive treatment.

The traditional custodians of the land in Sydney Local Health District are the Gadigal, Wangal and Bediagal people of the Eora Nation. Around one per cent of the population identify as being of Aboriginal and Torres Strait Islander heritage. The District is rich in cultural and social diversity and is home to a large number of established and emerging Culturally and Linguistically Diverse Communities. Approximately 46 per cent of the District's population speak a language other than English at home, including significant numbers of refugees, asylum seekers and special humanitarian entrants. A feature of the District's social diversity is our proud lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ+) community. A number of our suburbs have the highest proportions of same-sex couples in Australia.

Sydney Local Health District is characterised by socio-economic diversity, with pockets of both extreme advantage and extreme disadvantage. The District has the highest proportion of the States' Boarding Houses with 44 per cent of the 1062 Registered Boarding Houses in NSW, with an estimated 4800 Boarding House residents.

The District is made up of hospitals and health services delivered in various location in the community, virtually and in peoples homes. Our facilities include: Royal Price Alfred Hospital, Concord Hospital, Canterbury Hospital, Balmain Hospital, Sydney Dental Hospital, RPA Virtual Hospital, Concord Centre for Mental Health, Professor Marie Bashir Centre and Community Health Centres located at Croydon, Marrickville and Redfern.

In 2022/23 we provided care to more than 1.5 million people through our outpatient services, over 176,000 emergency department presentations and over 163,000 hospital admissions and discharges. Over 43,000 operations were performed in our hospitals and through our collaborative care arrangements, and close to 5,000 babies were born at Royal Prince Alfred and Canterbury Hospitals. Our Community Health Services delivered care to nearly 120,000 services at our community locations and close to 300,000 services were delivered virtually or in peoples' homes. The Sydney Health Care Interpreter Service received more than 69,000 requests and spent almost 55,000 hours interpreting for patients and their loved ones. The HealthPathways Sydney Program has enabled GP eReferral to over 70 services, with over 1100 eReferrals received monthly.

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	The NSW Local Health District (LHDs) structure has provided a good model and is well-embedded, having been in place for over ten years. It has enabled innovation and sound management at a health service level and population level, as the model recognises that health care is not homogenous and everyone is not the same. There will be nuances – and a story can be manifestly different when seen from a local community and/or health professional perspective.

patient-centred care and health services to the people of NSW, now and into the future	NSW and its health services are leading the country in a number of ways from the perspectives of other jurisdictions, and one of these is the strong relationship between the central authority (NSW Ministry of Health) and the LHDs. The NSW LHDs have a whole-of-health responsibility for their population, incorporating acute hospitals, community health, virtual care, population health and clinical services integration (as well as research and education),. This enables them to meet the health care needs of their respective populations and build partnerships with other local authorities such as Universities, Non-Government Organisations and Primary Healthcare Networks. This also enables clinical service innovation, as LHDs are able to affect many operational and strategic changes within their own organisational scope. One excellent example of this flexibility was the NSW Health response to the COVID pandemic. Another is the rapid SLHD establishment of RPA Virtual Hospital (rpaVirtual) in 2020, which was driven by SLHD and was remarkable timing given the COVID pandemic. rpaVirtual is a new and innovative way to deliver hospital level care in the community and provides a sustainable solution to the increasing demand on health care in Sydney. A purpose-built Virtual Care Centre operates 24 hours a day, 7 days a week and is equipped with 'Care Pods' that include videoconferencing technology and the ability to remotely monitor patients with wearables. rpavirtual acts both as an extension to existing health care services, as well as, providing purpose designed new health care services. The funding of innovative models of care, such as rpaVirtual, can be challenging under the current funding arrangements, as they do not fit neatly under the current Commonwealth classification systems. This problem also extends to some highly specialised low volume services such as pelvic exenteration, sarcoma and peritonectomy surgery. These highly specialised services which are usually state-wide services, are not sufficiently funded under the current Activity Based Funding model. In NSW Health, capital projects greater than $10M are overseen by Health Infrastructure in partnership with Local Health Districts. This brings together the expertise of Health Infrastructure with that of the LHDs in understanding their local assets, communities and environments. Capital programs under $10 M are managed by the LHDs. The appropriate funding of in-LHD capital and minor works, trades and trade support staff allows for the delivery of high quality, fit-for-purpose health facilities at a significantly reduced cost. Further to this, statewide strategic funding models, such as the Asset Renewal and Replacement program, have enabled LHDs to ensure that physical assets continue to support safe high quality patient care.

B. The existing governance and accountability structure of NSW Health, including: B1. the balance between central oversight and locally devolved decision making (including the current operating model of Local Health Districts)	Clinical governance structures in NSW Health ensure effective connection from front line care delivery to hospital and LHD Executive structures to Boards and Ministry of Health System Executive. These structures enable local decision making while ensuring central oversight of process and outcomes. There will continue to be a need to ensure strong joined up governance and accountability at every level of the health system. Future directions should continue to deliver a balance between central oversight by the Ministry of Health and locally devolved decision making for populations, while retaining what is currently value-adding. NSW has a structure that is well-regarded by other jurisdictions. On the whole, the stability in and maturity of the current NSW health governance structure has enabled embedding and balance. The Ministry has oversight of the system and connects with the Commonwealth context of health service delivery. LHDs have the service delivery knowledge base, have effective medical and staff leadership in health decision making, and have extensive experience in implementation. Innovation largely occurs in LHDs, and the Ministry takes on the role of leveraging these unique ideas across the system. The strength of NSW Health is that LHDs and the Ministry work together to co-design processes and models of care that aim to deliver better outcomes for the people of NSW. Local decision making is essential for patient and family centred care and for the ability to customise care on the ground. Local decision making optimises outcomes and reduces the need for work-arounds, re-admissions and additional costs. Centrally coordinated contracts require consultation with front line service providers to achieve value-based and fit-for purpose outcomes. Centrally (unilaterally) made decisions in procurement (eg Master Catalogue), without appropriate consultation with front line services, can result in patient safety risks. Where the system works in partnership these risks can be mitigated. Standardising and rationalising too much can lead to an increasing number of exceptions and subsequently to cost increases. For example, reducing the patient menu standards and standardising menus across the state, needs to be balanced with the duty of care to meet all dietary requirements for all patients. If the menu is too limited, more off-menu items will be required to meet patient needs, reducing potential cost savings generated by the standardisation. Greater patient deterioration risk is also well documented in acute facilities, where there is inadequate menu assistance and limited dietary oversight. The balance between central oversight and local decision making is critical and it is essential that those from front line services continue to have sufficient input into these decisions.

	While there is understandably an increased focus on central oversight of asset management expenditure (e.g. Minor Works & Equipment), locally devolved decision-making allows for the flexibility to undertake urgent works or works required in response to rapidly changing needs within a local context. The Single Digital Patient Record (SDPR) Implementation and proposed Operating Model of centralised core service delivery for information and technology services will be successful if it is co-designed with LHDs. There is a need for a strong partnership model which is clearly defined by a framework of controls and Service Level Agreements (SLAs), to ensure optimal outcomes for both NSW Health and the public we serve. The SDPR future governance model is still being defined, however, consideration of a safe operational transition from a LHD-managed eMR and clinical governance model, to a centrally managed eMR and Clinical Governance model needs to be prioritised.
B2. the engagement and involvement of local communities in health service development and delivery	The engagement of local communities in health service development and delivery is vital. It is essential to have community voices reflected in the planning for services, throughout all of the different levels from strategic to clinical service design. All services should have strong community partnerships, with engagement models drawing upon the diversity and strengths of the local community and health care workers. Examples for SLHD include: • The development of the SLHD Strategic Plan • The Canterbury Leaders Forum • The partnership between the AMS Redfern, SLHD, SESLHD, NSLHD, SCHN and St Vincents Hospital • Clinical Services Plans for Canterbury, Concord and RPA Hospitals • Yaralla Estate • RPA Health One at Green Square • Sarcoma Summit • The forensic mental health unit Community organisations are also engaged and involved in the provision of specific aspects of care. For example, engagement with schools and community managed organisations regarding Aboriginal youth mental health and wellbeing.
B3. how governance structures can support efficient implementation of state-	Governance structures must continue to include an operational focus when implementing state-wide reforms rather than a top-down approach. This will ensure strong engagement with LHDs and a smoother transition of revised practices into business as usual.

wide reform programs and a balance of system and local level needs and priorities	
B4. the impact of privatisation and outsourcing on the delivery of health services and health outcomes to the people of NSW	There are a number of examples where LHDs have utilised/contracted private health services to deliver services in the home, which have resulted in reduced service delivery. Many private nursing services depend on locum staff and have high turnover rates, which impacts on staff consistency and service delivery. A loss of equity of access, due to a lack of private health insurance as an example, can also be experienced by those most vulnerable in our society. Sydney District Nursing, which is part of SLHD, has demonstrated that the investment to keep these services under LHD governance and provided by LHD staff, with point of care connection to the electronic medical record and General Practices, is vital to good outcomes. In-LHD services further enhance health outcomes through their interaction with other in-LHD services, which provided comprehensive care by multidisciplinary teams resulting in high value and excellent outcomes for complex patients with comorbidities. Privatisation and outsourcing in relation to asset management can impact adversely on cost and clinical engagement when oversubscribed. There is strong evidence that having access to in-house asset management teams for project planning and execution is cost effective and fosters a collaborative environment with clinicians enabling delivery of health facilities which are fit-for-purpose and support staff to deliver excellent patient care.
B5. how governance structures can support a sustainable workforce and delivery of high quality, timely, equitable and accessible patient-centered care to improve the health of the NSW population	Governance structures and data reporting systems are recommended to be further optimised to measure and reduce unwarranted clinical variation and evaluate patient outcomes, as well as experience of care. The CEC QIDS Maternity Dashboard is an excellent example of this which could be extended to other areas of clinical practice. Clinical Quality Registries can also be developed to provide important information for services to optimise practice. The expertise and calibre of those leading NSW LHDs is substantial, and it has been possible for these clinical and executive leaders to foster good governance and clinical innovation. Some examples include: • Alignment of metropolitan LHDs with rural counterparts – for example, SLHD has developed clinical service delivery partnerships with Western NSW LHD and Far West LHD that have facilitated the development of new models of care and workforce strategies that have improved access to high quality, safe clinical care for example the vICU model of care between RPA and Broken Hill..

	• Highly effective clinical leadership in health decision making – medical, nursing and allied health engagement in Board committees and subcommittees (eg Clinical Councils), medical staff councils enshrined in LHD ByLaws, medical staff with Head of Department roles. These roles bring different perspectives to decision-making and service delivery and help to ensure that forward directions in clinical practice (including from the external world) are incorporated. • Rapid on-the ground responses to major health care challenges such as COVID, where SLHD worked in partnership with NSW Health and other LHDs to mobilise staff and resources to establish Vaccination Centres and the NSW Quarantine Accommodation program.
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	A well-defined funding model is required to ensure LHDs are equipped to provide the necessary resources and time to preventative and community health initiatives. This includes digital health investment for infrastructure, equipment and systems across Health. Consideration needs to be given to how patients in the community can access affordable resources for their care. Not all LHD provide dressings for patients that are registered with a community nursing service. This means that many patients with wounds need to purchase dressings that are often very expensive. This often means that they use cheaper products, resulting in delays in healing or increases chances of deterioration. This in turn may lead to them presenting to the Emergency Department or requiring ongoing community nursing. Consideration should also be given to the Commonwealth Government removing the limit of five visits per year across all private primary care allied health services, with limitations linked to access criteria. This could support private primary care services to provide adequate support for low and moderate-risk clients (for example this would allow people at high risk of developing foot complications to access higher acuity community-based primary care services linked to quaternary services).
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	Although it is recognised that shared services such as HealthShare NSW and eHealth play an important role in the NSW Health System and that increased standardisation across LHDs will be necessary in the future to ensure savings are realised, it is essential that there is transparency and accountability back to LHDs. It is essential that these services work in partnership with LHDs. Access to detailed and consistent reporting is essential for LHDs to be able to control their costs and for saving to be realised. Cost centre managers, whilst being held accountable, should have the capability to initiate local savings initiatives or efficiencies. Roadmaps must take a longer-term strategic view.

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	NSW Health is in the process of implementing significant procurement reform which is having positive outcomes for LHDs and our patients. The development of a state-wide formulary for pharmaceutical products has resulted in significant savings for LHDs. LHDs are at different levels of maturity when it comes to procurement with some LHDs requiring central support than others. Mature LHDs have expertise on the ground and can provide better value-based healthcare if involved in the decisions and strategies from the beginning. Front line services are able to see the opportunities and the waste. The particular complexities of clinical contract implementation need to be better understood and considered if real improvements are to be made. For Example, the market share model for prostheses contracts has made savings; however, this has proved exceedingly resource intensive to manage and monitor. Having a state-wide market share model, rather than an LHD based model, may be complicated and add additional risk and disincentive. High performing LHDs risk being penalised with increased pricing if other LHDs are unable to meet market share commitments in a single statewide market share model. It may rely upon clinicians will agreeing on a limited number of vendors (ie 2-3) for each prostheses category across the state, when service level delineation and requirements vary. A 2 tier pricing model for prostheses – metro vs rural, may be more appropriate. Most prostheses are utilised within the metro LHDs, and pricing is inflated to subsidise freight costs to rural and remote LHDs, where lower levels of activity occur. This inflates the costs of prostheses across the state. Improved pricing can be negotiated if vendors can focus on the majority metro market, separately to the rural requirements. The savings made by metro LHDs should more than offset the higher tier pricing of the rural LHDs, reducing expenditure overall. Centralising some tasks such as the purchasing of all ICT hardware (including items on government contract) to be approved by eHealth, will add another layer of processing. The strength of NSW Health has been the partnership between the Ministry of Health, the pillars and the LHDs. It is critical that as NSW Health moves to more standardised processes that this partnership approach is maintained. Implementation of central strategies such as the statewide formulary require the active engagement of Local Health Districts and their staff to be successful. For example, the DeliverEASE program has the potential to achieve significant outcomes and cost savings for the system if LHDs, eHealth and HealthShare work in partnership to determine the priorities for the program.

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: F1. the distribution of health workers in NSW	Our workforce in NSW Health is our most valuable resource. We have highly skilled and committed staff who come to work every day to make a difference in the lives of the people we service. This was evident during COVID-19 pandemic when our health staff did extraordinary things to keep or patients and the community safe from COVID-19 including setting up screening clinics, contact tracing, vaccination centres, hotel quarantine programs, setting up virtual hospitals and managing COVID-19 patients in our hospitals and in the community whilst still providing high quality clinical care in our hospitals and services, There is no doubt that the three years of COVID-19 has placed an inordinate toll on our health workers who are still recovering from the impact of COVID-19 and the recovery to business as usual services. The uncertainty and pressures brought about by crises, such as seasonal bushfires, devastating floods, climate change and pandemics such as COVID-19, has highlighted the requirement for immediate action and consideration to prepare for a range of potential events that may impact workforce capacity. The workforce is changing and so too are expectations about what is safe and what is acceptable in terms of quality of life and work life balance. Investing in the expansion of wellbeing programs to support all staff and exploring opportunities for the development of new initiatives will be required. NSW Health is working closely with LHDs to address issues of safe rostering practices with a particular focus on junior medical staff. Many senior medical staff are still working extended hours. While staff specialists nominally work a forty hour week, many are actually working much longer hours during weekdays, and when on–call, may spend considerable additional time in the hospital after hours, or for ward rounds at weekend, or working from home in the evenings. VMOs and part-time staff specialists may have several public and/or private hospital appointments, each of which has a patient caseload that requires their attendance at each hospital, which can impact service delivery. The public health system funds and contributes significantly to the training of health professionals including junior medical staff, allied health, technical staff such as sonographers and IT staff. Little training is provided in the private health system yet the public health system cannot compete with the incomes that these staff can earn in the private health system. Local Health Districts are constrained by the current award structures which act as a disincentive for these clinicians to work

	in the public health system. This is particularly evident in areas such as radiology, pathology and sonography. This contributes to staff feeling underpaid and under valued by the public health system. Work-life balance is more highly prized, both in terms of family and other non-work commitments, and also because of maintaining wellbeing – exercise, healthy eating, etc. There are more junior medical staff leaving their yearly attachments before the end of their annual contract. This adds to the caseload of the colleagues left behind and is increasingly seen as routine, when it was previously considered unsatisfactory. There are some definite areas of workforce shortage. These may be due to increasing demand (eg Anaesthetics), new technology (interventional procedures), private sector (salary differentials in radiology and surgery), highly specialised services (transplant). New medical workforce models/approaches are being developed (AiMs and IMG clinical readiness programs) but need to be sustained. Medical wellbeing and burnout are primary concerns for future workforce systems. One proposed recommendation is to build wider understanding of the different ways in which medical workforce roles and positions work together in health care. The integration of medical involvement in clinical service, teaching, research and hospital committees (quality, medication management, clinical councils) are essential roles of doctors in effective evidence-based service delivery. These roles and commitments are just as much part of the key accountabilities of medical staff as direct patient-facing care. In many cases, staff specialists carry many roles, however, VMOs also play important medical leadership roles (eg Heads of Department, Directors of Training). A core role in medical workforce management is provided by LHD/Hospital Directors of Medical Services, and there is often low levels of knowledge elsewhere about the differences between staff specialists, clinical academics and Visiting Medical Officers, and why these role are deployed in the way they are. These different staff categories are essential, as they reflect different ways in which clinical services operate, as well as the respective duties of each group. In modelling the medical workforce, it is important to understand these respective structures and roles, how to establish effective and efficient workforce profiles that ensure adequate staffing and patient safety aspects

	such as clinical supervision. In many cases, a VMO workforce model is the most effective way of providing senior medical resources. The implementation of the SDPR will impose an increased demand for digital health expertise. Arising from both the delivery and future operational demands, particularly during the transition period where hybrid platforms are maintained. This poses a risk to ongoing digital health services. The availability of more experienced nurses is limited in the market. Most new nurses come from new graduate programs and nurses in RACF and GP practices that have little to no acute care experience. The ability to deliver safe and efficient care is challenged by the funding allocation, which is based on wards and beds. Flexibility in funding for positions such as after-hours Clinical Nurse Educators and a move to 7 days a week service for our CNC and Nurse Practitioners is required. Mental health services are experiencing acute workforce pressures across nursing, allied health and medical (junior and senior) staffing. Some limited success has been achieved from international recruitment; however, registration and professional accreditation requirements have resulted in significant delays in this process.
F2. an examination of existing skills shortages	It has been identified that there are difficulties in recruiting to nursing, medical (specialist), allied health, IT and workforce roles. Positions are being re-advertised due to a lack of both candidates and candidates who do not have requisite skill level and/or experience for roles. There is a need for better pathways for new graduates and school leavers whereby more on the job training can be provided to enhance capabilities. Support can also be provided by external obtainment of qualification whilst working. LHDs need to work collaboratively with internal and external partners including Universities, Non-Government Organisations, Government Organisations, other Local Health Districts and NSW Health pillars such as the Clinical Excellence Commission (CEC), Health Educational and Training Institute (HETI), the NSW Health RTO, and the Agency for Clinical Innovation (ACI) to create opportunities for learning as well as ensuring that the education we deliver is informed by State level strategic priorities.

	Implementation of digital technologies will be compromised across the sector largely due to skills gaps in health workers' capability in using/adapting to the technologies. The skill gap analysis and required training to implement/adapt is not keeping up to the pace of new technologies being implemented. This is exacerbated by demand, inhibiting capacity for the majority of clinical staff and specialist service management mechanisms. Skills training e.g. traineeships and apprenticeships should be embedded into workforce planning. Recruitment to identified Aboriginal and Torres Strait Islander positions within mental health services, remains a challenge across the State. SLHD has invested in establishing a Workplace Competency Development Program and associated Diploma in Mental Health for staff entering community mental health services, to ensure staff attain the necessary knowledge and skills to provide high quality care. In previous years, HETI provided training for community clinicians; however, apart from Accredited Person Training this is no longer available. 1. Training opportunities for hard to recruit to positions remains a challenge. A few examples are provided: 2. Cardiovascular Perfusion - SLHD has had to develop and seek accreditation for a Graduate Diploma of Cadiovascular Perfusion. This is because there is no nationally recognised tertiary qualification for doctors who specialise in cardiovascular perfusion. 3. Aboriginal Health Practitioner (AHP) - there are only two sites within NSW that offer the required qualification for candidates to become an AHP (requiring registration). The AHPRA website reports that there are only 51 individuals who hold the Aboriginal and Torres Strait Islander Health Practitioner registration in NSW. 4. Sonographers, in particular cardiac sonographers – there is a shortage within the public health system. Again, there is limited training sites within NSW and if recruited and trained in the public health system, transfer to the private sector where remuneration is greater. 5. Medical Radiation Scientists (MRS) – the four-year degree (which is no longer available in NSW) commenced around four to five years ago and includes a 4th year comprising 36 weeks of placements under which the students are trained on the job in various modalities which is equivalent to the first year of employment.

F3. evaluating financial and non-financial factors impacting on the retention and attraction of staff	Industrial awards and salary levels drives workforce movements (including to private sector). Anecdotal evidence is that NSW is now well-behind other states in terms of base salaries for doctors and nurses. The differential in two recent examples was more than $150k each. The NSW Health Staff Specialists (State) Award is antiquated and inflexible, and many sections are no longer fit for purpose. Areas to be considered include practice across a seven-day week, remuneration for doctors involved in virtual care delivery, and provision for those who work greater than forty hour weeks due to additional/weekend/onerous hours duties. Cost of living pressures is having a significant impact on recruitment and retention of staff on lower pay rates, such as those in face to face administration, clerical, portering and cleaning roles, as many cannot afford to live close to metro LHD local government areas. Commuting and road tolls also deter those living further away from working in metro LHDs. As per F2, salaries and conditions offered are ordinarily not at a level being offered elsewhere such as in the private sector. Non – financial factors impacting on retention and attraction can include working from home arrangements for non-clinical staff, where private sector can be more flexible in arrangements and easily available car parking (which isn't the case with many metro hospitals). In addition, the market and shortages of skilled staff has been impacted by Covid, whereby overseas students who have historically filled positions had been limited. The changes to Immigration and entries uptake may see some easing of attraction to health positions. In the 2023 PMES survey, a significant number of staff within SLHD and across NSW Health indicated intention to apply for roles in other NSW public sector organisations – this presents real financial (costs of replacing/training staff) and non-financial impacts (prospects of losing valuable clinical skills, local knowledge and expertise) that will affect our ability to meet the current and future needs of patients, their families and our staff. This is further exacerbated by an inability to successfully fill existing clinical and non-clinical roles when they become vacant. The data suggests this problem will continue. Significant attention and prioritisation of this trend will be required with the intention to attract and retain both clinical and non- clinical across the system, particularly when other states in Australia are providing incentives to attract our talent to their Health Services.

	There are current limitations to the access and analysis of internal workforce data and labour market data impacting LHD capabilities to meaningfully evaluate financial and non-financial factors of retention and attraction. Factors such as budgetary cycles, year on year training progression for critical workforces, fluctuation in labour market availability with unpredictable graduate and international intakes annually all play critical roles in determining cost and impact of workforce shortages. For example, the impact of a speciality not able to recruit all Junior Medical Officer (JMO) positions for the clinical year intake will vary widely depending on the speciality and timing with limited time availability to adjust to efficient solutions. Awards require review, to ensure consistency with industry best practice, particularly around pay rates. This will support attraction and retention of appropriately qualified, skilled and experienced staff. There is a trend for new graduates to be recruited by private allied health practices whilst they are still a student, which reduces the new graduate pools for positions in NSW Health. Marketing campaigns by private allied health practices are offering incentives regarding financial support for professional development, which NSW Health is unable to offer as it is not included in the allied health awards. There is difficulty in the recruitment of experienced and skilled information technology staff in the LHDs. The private market is offering more in this industry and this is further compounded by the differences within NSW Health for similar levels of responsibility with higher pay grading. It is observed, information technology staff are paid at a higher grade in eHealth, Ministry of Health and the private sector.
F4. existing employment standards	Employment standards are determined centrally by the Ministry of Health, with LHDs having no legislative authority to offer employment conditions outside of those prescribed. Allied health and all award reforms is required, with current awards being several years old and not contemporary for some professions (e.g. Pharmacy and Medical Radiation Scientists).
F5. the role and scope of workforce accreditation and registration	Australia has gained a great deal from the way in which its specialist medical training is delivered, as it has resulted in excellent health care through expert staff who have the kind of skills and knowledge to effectively care for patients and families. Colleges are also held to National Education Standards (guided by the Australian Medical Council) that are closely linked to the registration

	authority (AHPRA). Despite the significant investment by public health services in specialist medical training and the fact that public Health services are the primary employer of doctors in training, the approach taken by Colleges tends to take a combative rather than collaborative approach with LHDs to provide high quality specialty training. Colleges have withdrawn accreditation of hospital training with little notice or opportunity to resolve issues leading to major service and patient care challenges. SLHD is one of the LHDs that has invested resources to support medical accreditation (In SLHD Executive Medical Services) Workforce accreditation and registration requires administrative investment to ensure compliance. For example, with Working With Children Legislation, LHDs are required to have staff working with children, provide a valid check which will come up for renewal at differing times for each individual. Under the legislation, if a staff member doesn't have the WWCC verification, the LHD is unable to allow the staff member to work until verification provided (or at least have the check in progress). This requires a significant Workforce response such that relevant staff and Managers are informed at least a month in advance, the WWCC is coming up for renewal. Follow ups then occur with relevant staff and Departments and on occasion, involvement from the General Manager to ensure staff members do not work until the check is obtained and provided by the staff member. The dependency on external organisations such as AHPRA correlate to costs and workforce requirements from LHDs, where changes or new registrations being added introduce an immediate cost to an LHD or barriers to new/emerging workforces such as Aboriginal Health Practitioner roles – where registration is required, though pathways to achieve accreditation are limited.
F6. the skill mix, distribution and scope of practice of the health workforce	Skill mix and scope of practice are heavily influenced by Award employment conditions. For instance, as a general comment, HSU Awards cover clinical support roles such as administrative, cleaning, security and portering roles and Allied Health roles; ASMOF Awards cover junior and senior medical roles and NSWNMA cover Nurses Award. There is cross over in tightly defined employment roles and can lead to demarcation issues as to the appropriate skill mix. An example of this is the cross over in infectious cleaning related duties between HSU covered staff (Hospital Assistants) and Nursing (Both Registered and Enrolled).
F7. the use of locums, Visiting Medical Officers, agency staff and other temporary staff arrangements	With hybrid and gig economy trends, more people are seeking short term work at hours that suit them; therefore, choose casual or locum work, at the expense of permanent employment (eg nurses). In the current employment climate, the need for agency and temporary staff will continue.

	While the Nurses and Midwives conditions of employment provide for rotating shift work over a seven day period, more nurses and midwives are electing to not accept these roles but choosing positions where they can elect to work particular shifts (such as no night duty, etc). This is often accommodated as casual or part time employees. There is confusion over the arrangements covering Junior Medical Officers. For example, the Employment and Management of Locum Medical Officers MOH Policy at section 2 prescribes that LHDs must only source locums through specific agencies. Under the policy framework there are set rates. This policy does not allow for the direct engagement of Medical Officers as Locums by the LHD. The Employment Arrangements for Medical Officers similarly does not provide for engagement of locums. There is misunderstanding of this application of policy and how casual arrangements can be entered into for Junior and Senior Medical Officers. There is confusion over the arrangements covering Senior Medical staff and Visiting Medical Officers (VMOs). This occurs with a number of Awards, Determinations and Policies covering that area including legislative provisions of the Health Services Act applying to VMOs. This in turn creates challenges with flexibility in recruiting staff, meeting operational service delivery requirements and ensuring compliance with centrally determined conditions of engagement. The creation of lower rates of pay for Staff Specialists but higher rates for VMOs has also caused unintended scenarios to arise where staff seek to end ongoing employment arrangements to be hired but paid more contractor VMO roles. It is recommended a review of Junior/Senior Medical Officers and VMO arrangements would assist in meeting service delivery demands.
F8. the relationship between NSW Health agencies and medical practitioners	In the medical area, it is common for Heads of Department to be engaged as Contractors (VMOs) as opposed to employees. The VMOs will ordinarily have outside private practice arrangements which involves investment by an LHD to ensure appropriate conflicts of interest do not exist with their practice companies. LHDs will engage directly with medical practitioners for instance in their roles as HODs (as above) but also on a collective basis such as Medical Staff Councils and through their Union representatives (ASMOF). The AMA do not have rights to represent employed medical staff but do represent VMOs.

	LHDs must engage with many stakeholders concerning medical practitioners. This can lead to a wide variety of claims put to the LHD (for eg on pay claims) but ultimately the LHD is required to maintain compliance with MOH determined conditions of employment.
F9. opportunities for an expanded scope of practice for paramedics, community and allied health workers, nurses and/or midwives	There is an opportunity to invest more in Nurse Practitioners to reach more of the vulnerable clients that may not be presenting to GPs for their primary health care needs. Allied health clinicians working at their full scope of practice, i.e. 'advanced scope' or 'extended scope of practice' allows the Allied health clinician to utilise their full set of skills to manage patients with a variety of clinical presentations as part of Allied health led clinics, which would free up medical and nursing staff to see higher acuity/priority patients. Allied health clinicians working at full scope of practice allow high quality care to be provided to consumers in place – whether this is their own home, their GP clinic, residential aged care facility, etc. It minimises the need for travel to specialist centres, the resources this might take (e.g. ambulance transport), the economic and time burden to consumers and their carers, can reduce wait time for specialist intervention and can even prevent hospital admission. Specific conditions for Physiotherapy include Musculoskeletal, Orthopaedic, and Neurological conditions; for Podiatry - diabetes-related foot disease, complications due to peripheral artery disease, or biomechanical pathology including Non-medical prescribing and referral to pathology and diagnostic testing; For Dietetics - upskilling of GPs, dietitians and nursing around gastrostomy care, including identification and trouble-shooting for gastrostomy sites and early referral for complications and prescribing rights for dietitians around pancreatic enzyme replacement therapy Mental health services have increased the establishment and recruitment to transitional nurse practitioner / nurse practitioner positions to enhance senior clinical roles. It is recommended that the emergency departments transition to first line senior nursing assessment by such positions, in recognition of unsustainable workload pressure on the junior medical workforce.
F10. the role of multi-disciplinary community health services in meeting current and future demand and reducing pressure on the hospital system	The role played by multidisciplinary community health services is multifaceted and has indeed been expanding its capacity and capabilities in response to more acute services being provided in patient's homes and virtually. These services continue to have vital roles in health prevention and promotion; post hospital discharge care, chronic care and palliative care and across the full life age span. It is important to maintain the provision of multidisciplinary services provided by public sector, in addition to services provided by NGOs that are networked closely with the Primary Care Professionals.

	Numerous evaluations have demonstrated that hospital avoidance can be increased through early intervention and earlier discharge from hospital through access to services in the home. SLHD has many examples of programs that demonstrate the importance of having services provided outside hospitals that are effective: • Healthy Homes and Neighbourhoods: • Living Well Living Longer: • Hospital in the Home • rpaVirtual • PEER and Community Health workers/navigators • ED to Community • RPA Health One Green Square • Homeless and Rough Sleepers • Child and Family Hubs Services are broad ranging and are integrated with other Government agencies in addition to General Practice, specialist services and NGO services. These services particularly target the most vulnerable in our community and integrate not only with the acute sector (hospitals) but with all services involved in the patient care. For example, the Integrated Community Care Team, in partnership with the Central Eastern Sydney Primary Health Network, improves access to primary and integrated care within communities experiencing high locational disadvantage, including Waerloo, Redfern and Riverwood. Healthy Homes and Neighbourhoods (HHAN) provides 'whole od family' care in the community to families with complex health and social care needs to assist each family to across the services they need. HHAN works with other community works to link families to the right service at the right time. The Living Well, Living Longer integrated care program celebrated 10 years in 2023. The Program has improved the number of mental health consumers with a named General Practitioner, introduced a formalised shared care arrangement between the mental health service and general practice and introduced health peer workers to use their lived experience to support consumers in their physical health.

	SLHD has the highest proportion of the largest Non Government Organisation (NGO) portfolio in NSW with over $20 million in grants across 32 NGOs. This included grants for Drug and Alcohol programs, Mental Health, Aged Care and others. An example for a community-based primary care allied health services is provided in the literature for Podiatry as per below • In Australia, 50% of people with diabetes and foot ulcers have underlying Peripheral Arterial Disease (Schaper et al., 2021), • Consumers: Patients will be triaged by a primary contact clinician and, where appropriate, undertake a podiatry review and assessment along with a potential trial of conservative treatment before any surgical review • Health care practitioners: Vascular Surgeon/Registrar will receive timely and appropriate referrals, • Healthcare system: reduction in vascular surgery specialist clinics waitlist, reduction in wait time for an initial assessment for all vascular surgery patients, lower risk patients can trial conservative management more quickly, patients likely to require surgical intervention will receive surgical opinion more quickly (Farndon et al., 2018). Preventative or step-down community-based (outpatient) primary care podiatry services. • Consumers: provide timely and comprehensive foot care for people with previous foot ulceration or increased foot disease risk. For people with diabetes and previous foot ulceration, the risk of re-ulceration is 50%, necessitating ongoing routine foot checks and care with appropriate referral to appropriate interdisciplinary high-risk foot services that have been shown to significantly reduce the risk of amputation when referred promptly, per the national FootForward.org.au guidelines. Private primary care services only sometimes have the skill base, and the costs are prohibitive for people requiring regular review outside the Medicare-rebated five visits (APodA, 2022; Davis et al., 2018; Kaminski et al., 2022). • Healthcare system: reduced acuity and severity of foot disease necessitating fewer hospital bed days. SLHD also has a broad range of established community mental health teams that provided services across the lifespan, with adolescent, adult and older adult services.
F11. opportunities and quality of care outcomes in maintaining direct employment arrangements with health workers	

G. Current education and training programs for specialist clinicians and their sustainability to meet future needs, including: G1. placements	The NSW public health sector plays two core education/training roles: • Educating and training the health professionals of the future, and • Ensuring staff maintain their professional competency and have access to training and skills development that they need to fulfil their roles. There are several organisational advantages to this, including: • Almost all junior medical staff (interns to registrars) are Doctors-in-Training, and so provide the workforce for medical teams. • Students across all disciplines who have positive experiences during training may choose to apply to work in the hospital/LHD in which they trained, therefore positively contributing to workforce sustainability. • It promotes a learning organisation and enhances adoption of best practice in clinical care, as this is what is being taught to students. • Experienced health professionals enjoy teaching and are energised by the curiosity and questions of student, and this contributes to their workplace satisfaction and wellbeing. Some key issues for consideration: • As clinical services grow and develop, they require additional staff. However, service enhancements rarely provide for additional training capacity to train the health professionals of the future. Training capacity is not only about additional clinical placements, as it also would involve provision of dedicated time for senior clinicians to teach, train and mentor, and educational facilities and resources. These are sometime seen as good things to have, rather than intrinsically necessary. • There is sometime criticism of education and training programs for specialist clinicians because of their so-called “silo approach”. It is important to recognise that a primary outcome of training is to produce expert clinicians in that discipline, and the current Australian training programs need to be recognised for and congratulated in currently achieving this. • Notwithstanding this, there are opportunities to look at undergraduate and postgraduate approaches to training that enable skills in teamwork across disciplines, effective communication/feedback and managing change, as these are skills increasingly relevant to health professionals now and in the future. • While senior medical staff have award provisions for continuing professional development, study leave for other professional groups is less well-developed. There are also sometimes perceptions (especially in the context of resource management) that continuing professional development is a luxury, rather than essential to maintain currency of practice in a rapidly

	evolving patient care context. The changes in the Medical Registration standard to formalise professional development requirements to retain medical registration reflect the relevance of continuing education of health professionals. There are current discussions about the role of Specialist Medical Colleges and their interface with LHDs and jurisdictions. Australia has gained a great deal from the way in which its specialist medical training is delivered, as it has resulted in excellent health care through expert staff who have the kind of skills and knowledge to effectively care for patients and families. Colleges are also held to National Education Standards (guided by the Australian Medical Council) that are closely linked to the registration authority (AHPRA). Some of the current discussions about the role of Colleges seem to focus more on the relatively few situations where training (particularly trainee wellbeing) is seen to be of concern, and on the associated communication between Colleges, Hospitals and jurisdictions in settings where potential withdrawal of accreditation of training arises. This is communication currently being addressed in several national and jurisdictional settings. However, there is potential risk to current excellence in health care delivery should this situation be seen as a common scenario, when the majority of specialist medical training is adequately governed through standard accreditation procedures, and where gaps in training programs are identified, these are addressed well before the stage of requiring withdrawal of accreditation and/or trainees from the training site. Finally, Colleges have sometimes been seen as putting up barriers to workforce expansion by limiting the number of training positions. But the experiences of DMSs involved in medical accreditation at a hospital level in recent years do not support this view. In most recent cases, Colleges have welcome (and even suggested) additional training positions. However, funding for training positions comes from the hospitals, which of course, also employ Trainees for service delivery reasons, and the most common reason for not increasing training positions is about availability/prioritisation of funding for additional training positions, even where there is a strong case due to clinical service demands (most recently in Rehabilitation Medicine at RPAH).
G2. the way training is offered and overseen (including for internationally trained specialists)	Within mental health services, the substantial comparability pathway for overseas trained psychiatrists remains slow and complicated and the complex relationship with AHPRA registration, places barriers to international recruitment.

G3. how colleges support and respond to escalating community demand for services	We are advised that colleges advocate directly to the Ministry of Health where it perceives widespread unmet need or service pressure; for example, the Safeguards Committee and the Staff Specialist Award.
G4. the engagement between medical colleges and local health districts and speciality health networks	Colleges oversees the Training Network, approves new training positions and seeks confirmation that existing positions meet accreditation requirements. The colleges generally escalate system wide issues directly to the Ministry of Health , rather than to the Districts directly.
G5. how barriers to workforce expansion can be addressed to increase the supply, accessibility and affordability of specialist clinical services in healthcare workers in NSW	Review of staffing awards, noting the previously mentioned differences in renumeration when compared to other States.
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	SLHD has introduced new digitally enabled models of care including: • **RPA Virtual Hospital** – a personalised service for the community providing patients and their carers with 24/7 support. New models of care and outreach programs are provided to patients. • **vICU in partnership with FWLHD** implemented in April 2022 - the vICU Service provides support to Far West Local Health District Intensive Care Unit, connecting clinicians, patients, and carers from Broken Hill Base Hospital with nursing and medical staff at Royal Prince Alfred Intensive Care Service. vICU provides 24/7 virtual care advice and education via video conferencing and telephone calls, to support clinical services provided by Broken Hill Base Hospital for critically unwell patients. • **Florence** - the District's digital patient portal and appointment booking system live in 83 Clinics and 18 Departments. • **Virtual Wound Care** - the Leading Better Value Care Standards for Wound Management is a statewide initiative to improve wound care services. In line with this, SLHD has implemented a new model of care for wound management that utilises a Digital Wound Application in the hospital, community and as part of the Virtual Wound Care Command Centre (eWCC). The model aims to improve assessment, management and documentation processes for all patients with wounds specifically complex and chronic wounds. • Pilot of a new **telehealth module for Residential Aged Care Facilities** in May 2023 - aims to reduce hospital emergency admissions from Aged Care facilities by connecting SLHD's clinicians and facility care workers via a Telehealth call to triage the patient.

	Together with the University of Sydney and NSW Ministry of Health, Sydney Local Health District is jointly leading the development of a state-of-the-art biomedical research and innovation precinct, titled the Sydney Biomedical Accelerator (SBA) complex. The vision for the SBA is to accelerate the translation of biomedical research into clinical practice, which includes advances to therapeutic treatments, clinical service delivery, and innovative solutions for the health challenges of today and in future. The SBA will achieve this vision by establishing an ecosystem promoting innovation and physically co-locating internationally-recognised clinicians, academics, researchers and industry partners across a diverse health and biomedical disciplinary spectrum. Health outcomes could be improved through the establishment of community hubs, with the aim of providing early intervention for child and family in the first 2000 days. Consideration should be given in the development of any new model of care to integration across the whole health system.
I. Any other matter reasonably incidental to a matter referred to in paragraphs A to H, or which the Commissioner believes is reasonably relevant to the inquiry	
AND FURTHER, WE authorise you to make recommendations to address the issues raised including in relation to National structures or settings, including the National public hospital funding model and/or National Health Reform Agreement and the impact of aged and disability care in NSW public hospitals, where such recommendations would support or enhance any changes recommended by the Special Commission	