Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

At Level 2, 121 Macquarie Street,
Sydney, New South Wales

Monday, 22 July 2024 at 10.00am

(Day 036)

Mr Ed Muston SC	**(Senior Counsel Assisting)**
Mr Ross Glover	**(Counsel Assisting)**
Dr Tamsin Waterhouse	**(Counsel Assisting)**
Mr Ian Fraser	**(Counsel Assisting)**
Mr Daniel Fuller	**(Counsel Assisting)**

Also present:

Mr Richard Cheney SC with Mr Hilbert Chiu for NSW Health

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THE COMMISSIONER: Good morning, everyone. In a moment, I will invite Mr Muston SC to deliver an opening statement for this hearing block for the Special Commission of Inquiry into Healthcare Funding, but before I do that, I acknowledge the Gadigal people of the Eora nation, traditional owners of the land on which we gather today and pay my respects to their Elders, past, present and emerging.

Mr Muston?

MR MUSTON: Thank you, Commissioner.

Today we embark on our first hearing, which deals specifically with workforce issues. It is by no means the first time we're hearing about workforce challenges within the public health system. They have been extensively addressed in evidence given during both the opening hearing block last November but also they've been a recurring theme in our regional and rural hearings, where many of the workforce challenges are particularly acute.

A clear picture is already emerging that workforce challenges are both endemic and have a pernicious effect on the public health system.

In saying that, that's from the perspective not only of its ability to deliver the care that it needs to deliver, but also in terms of its long-term economic viability.

But these issues are not only not new to this Inquiry, they are not new to the health system. Much of what we will be hearing fairly closely reflects the content of a report of the NSW Health Council prepared in March 2000, which is proposed to be exhibit H2.1. I won't take you to that now but park it in your mind because it does, at least, as best as we interpret it, seem to reflect fairly closely the same challenges as we are being told exist and proposes some of the same solutions that we anticipate going forward people will suggest ought be applied to those challenges.

But during this hearing block, we will be taking a closer look at some of the particular challenges.

Before touching on the areas that we're going to

examine over the next few weeks, we think it might be worth noting something about the approach we intend to take.

In this hearing block, we're going to look at the current state and composition of the health workforce in New South Wales, and in particular, its medical staff, nurses, midwives and allied health professionals; and a current approach to the training, recruitment and engagement of the health workforce within the public system; and, finally, current and future issues and challenges relating to training, recruitment and retention of a suitable health workforce and one which is capable of meeting the current and future health needs of the population.

In essence what we're seeking to do is establish something of a baseline and then pick out of that some key challenges, or at least some pervasive systemic challenges that this Inquiry might usefully make some recommendations about.

In relation to the baseline, we have received and propose to tender a report prepared by Rian Thompson. Mr Thompson is a director of the workforce insight and transformation workforce planning and talent development branch, which is a bit of a mouthful, but his report provides a useful point in time snapshot of much of what we've just stepped through - that is to say, the composition of the existing health workforce. It can be found at [MOH.0010.0377.0001]. I won't take you to it now but in due course, it will be tendered.

I should add, it is not our current intention to call Mr Thompson to speak to his report. It is essentially a report which sets out his work analysing much of the data that is kept by NSW Health and setting it out in what we think is a more digestible form for our purposes.

That's the baseline. Identifying some of the key challenges is obviously going to be a slightly more elaborate exercise, but - and this is in the context of explaining our approach - having identified those challenges or identified challenges that we think the Inquiry can usefully or potentially make some recommendations in relation to, it's our intention to return to them in hearings scheduled for October, in which we propose to focus on the identification and consideration

of some potential responses or solutions to those challenges.

Now, as part of that process, we intend to release a discussion paper well in advance of those hearings, which identifies what we see as the key challenges rattling out of this immediate hearing block, in the hope that by doing so, we will be able to better direct the exercise we're undertaking in October from an evidentiary perspective, if nothing else.

But moving to the particular issues we intend to explore during the immediate hearing block, the first, which I described a few moments ago as "setting the baseline" is, as I noted, the current state and composition of the health workforce.

We intend to examine the number and distribution of employees within the health workforce, differentiated by their discipline in the LHD or specialty network in which they work. In each case we'll endeavour to understand how workforce shortages affect the delivery of care through the public health system in the LHDs and specialty networks and potentially the reasons for those shortages.

As I said not a few moments ago, our workforce shortages and maldistribution have each been very much recurring themes in the evidence received by the Inquiry to date and particularly in the rural and regional areas.

We intend to touch on the utilisation of what has been described as "premium labour", which broadly captures overtime agency staff and medical locums. And related to this, we'll have a look at the different ways in which the medical workforce is retained, the divide between salaried staff specialists, VMOs and locums and the role that each of those particular forms of retention does, or ideally should play, within the health system.

As I've already noted, much of that, what I have just been through, is addressed in Mr Thompson's report.

Building a little bit on Mr Thompson's report, we are also going to look at the types of workforce data which are being collected by NSW Health and the extent to which they're being utilised in the context of workforce planning at a statewide and at a local level, and if so, how they're

being used. We'll look a little bit more broadly in that context at the nature and efficacy of some of the existing planning activities insofar as they relate to workforce.

That probably brings us to the next core issue that we're going to touch on during this hearing block, which is training. We anticipate there's going to be fairly broad agreement between all of the relevant stakeholders that good training pathways are critical to meeting many of the workforce challenges.

The evidence that we will hear over the coming weeks will touch on a wide range of training issues and some initiatives across the workforce, but we do intend to look a little bit more closely at several issues which appear to have been a more prominent feature of some of the submissions received.

The first is vocational training of medical specialists. Shortages and maldistribution of particular specialists and sub-specialists again have been a strong feature of both the evidence that the Inquiry has received to date and also the submissions received, particularly in rural and regional areas.

Against that background, it's our view that training pathways, insofar as they relate to those specialists and sub-specialists, are particularly important.

Specialist training pathways do vary from one area of specialisation to another and appear to have many moving parts, as we will discover as the evidence rolls out, but it has been suggested that there are some blockages in some of these training pathways which are contributing to the workforce challenges, particularly the shortages and maldistribution.

That is probably not an enormously controversial proposition. What is more controversial, or the area in which there seemed to be strongly conflicting views, is the source of these blockages. We don't intend to go too far into the wrongs and rights of any particular training decision made regarding any particular specialisation at any particular facility, but we will hear from a number of specialist colleges regarding their involvement in the training of their prospective fellows and we will hear their view as to where they think some of the potential

blockages or what some of the limiting factors are in terms of their ability or the ability for the broader system to train and deliver more specialists and sub-specialists.

We'll also hear from LHD and ministry witnesses involved in the training of these specialists with a view to understanding their perspective on where those potential blockages lie and what the key integers in the training pathways are so that we can try and make some assessment of where the challenges might realistically lie.

I should say in this area, we are building on a very substantial body of work which has already been done by the National Health Practitioner Ombudsman, who has issued a report dealing with it. It's certainly not our intention to traverse ground already covered extensively by that work and, if so, certainly not to any significant degree.

We'll also be building on evidence that we've gathered during our regional hearings in relation to the relationship between universities and other tertiary training entities in the public system, particularly insofar as not so much specialist training is concerned, or the vocational training for specialists is concerned, but more the training of medical graduates, interaction between the universities and public health system for the delivery of clinical placements, and the training of medical graduates during that first PGY1 year that they have, but also interactions between the universities and LHDs in other parts of the public health system which deal with the training of allied health professionals and nursing staff.

Now, one particular issue that has been touched on in submissions and discussions that the Inquiry team has had with various stakeholders in that space, particularly the allied health space, is the availability of clinical placement positions.

Something that we will explore is the extent to which the availability of those clinical placements, particularly for allied health professionals, is operating as a limiting factor in the system's ability to produce more allied health professionals across a range of disciplines and shortages and maldistribution of allied health professionals, particularly against the background of the pressure being imposed upon that particular sector of the workforce by aged care and the NDIS, for example, which is

an issue that does, we think, need to be grappled with.

Now, before moving on from training, it's probably worth observing that the public health system, and especially public hospitals, do play a very significant role in the training of the state's health workforce. But for various reasons, it does appear that the public system struggles to retain within its own workforce many of the people it has committed significant time, money and effort to training, which probably leads us nicely to the next issue that we intend to explore over the coming weeks, which is recruitment and retention of the health workforce within the public system.

There is an obvious overlap between the training pathways and recruitment. Having said that, recruitment also occurs from outside of these training pathways, including recruitment of internationally trained and qualified health workers. We will have a look at some of those other pathways into the health workforce, although again, we note that a significant amount of work, particularly in relation to internationally trained medical graduates, has been done in Kruk review, and we don't intend to revisit work done there.

Evidence is going to touch on recruitment practices, but also, and perhaps more significantly, on some of the issues driving retention issues within the workforce, once people have been recruited. These retention issues we anticipate are multifactorial and messily human, but we'll look at a range of issues which have been touched on in the submissions and are picked up in the evidence, including the way that NSW Health and its component parts assess the satisfaction of its workforce; the manner in which those administering the public health system consult with the workforce on issues of planning; and in addressing concerns and grievances that the workforce might have about the way in which the system's operating; and the handling of complaints against members of the workforce.

Obviously in respect of that last piece, very difficult to assess at a systemic level, and it's not our intention to dive into, at least not in too much detail, the rights and wrongs of any particular disciplinary matter which has been determined, although we are alive to the suggestion which has been made in several submissions that the disciplinary system is, to use the term that's

repeatedly been used, "weaponised" against those who speak out, and we just intend to try to come to understand, at least so far as that is suggested, what that means and what it might broadly look like from the perspective not only of the clinician but also of the system dealing with the complaints. Undoubtedly the views in respect of those issues will differ depending on the perspective you are looking at them from.

Other issues which are central to recruitment and retention are remuneration of working conditions which are available to prospective and existing members of the health workforce in New South Wales. We anticipate on these fronts that we will be told both present very serious challenges and, interestingly, we anticipate that there's probably going to be some uniformity in the evidence which is given on these issues by witnesses from within the Ministry of Health on the one hand and also from groups representing different elements of the workforce on the other, including the Health Services Union, the Australian Medical Association and ASMOF, the industrial body that represents salaried medical professionals, in essence, the staff specialists.

We expect the Inquiry will be told from both sides of the ledger that the cap on public sector wage increases in New South Wales over the past decade or so has had a very serious and negative impact on recruitment and retention of the permanent health workforce.

We also expect the Inquiry will be told that many of the industrial awards governing employment conditions within the health sector are outdated and in need of total reform. The sense one gets from the submissions received and an examination of the industrial awards is that the awards have simply failed to adapt to very significant changes in the way in which health care is delivered within a contemporary environment and the way in which the health workforce is utilised for that purpose.

One thing that is potentially symptomatic of that is the emergence of what have been described as "non-standard" arrangements, essentially arrangements with members of the health workforce which sit in some respects slightly uncomfortably with the strict terms of the industrial awards. In some cases, those arrangements are approved via a formal process by the health secretary. In other cases,

they would appear to have grown more organically.

We will examine the non-standard arrangements at a relatively high level with a view to identifying some of the particular challenges they present, rather than getting into the, again, rights and wrongs of whether a particular payment made to a particular person at a particular facility is appropriate or inappropriate. That's not really the role of this Inquiry.

The particular challenges that the non-standard arrangements present, at least potentially, include the following: first, people within the public sector being paid differently or enjoying different conditions whilst doing the same job, albeit in a different part of the same health system, appears to have the potential to cause friction and impact on workforce satisfaction and retention.

THE COMMISSIONER: The allegedly outdated awards and the, as a matter of fact, public sector wage freeze, have they driven these arrangements that you're talking about?

MR MUSTON: That's something we will need to explore. I infer that's a possibility, which is why I said a moment ago that these non-standard arrangements are potentially symptomatic of the level of remuneration within the public system when compared to the private system and potentially when compared with public sector remuneration in our neighbour states and likewise, to the extent that the industrial awards do not actually reflect the contemporary practice in terms of the delivery of medicine, adaptation which might be made --

THE COMMISSIONER: By "the contemporary practice of medicine" you mean the fact that hospitals run 24 hours a day seven days a week?

MR MUSTON: And staff specialists in many areas, I suspect, don't work eight to five.

THE COMMISSIONER: Yes.

MR MUSTON: They work much longer hours, as is necessary for them to maintain the continuity of service that is offered through public hospitals in this state.

So the first issue is the potential impact or the friction that paying people differently in different facilities to do the same job has the capacity to cause. The second issue is, particularly in relation to those more organically developed non-standard arrangements, any attempt to rectify or wind them back has the potential, we would think, to cause workforce dissatisfaction and industrial disputation, both of which have a knock-on effect in terms of retention and recruitment to the public health system.

What we intend to do at the end of this hearing block is round it out by looking at some recent events at Concord Hospital which potentially present a neat case study of how many of the issues that we've just touched on come together to produce what is potentially a spiralling and negative impact on the health workforce and the delivery of care at that particular site.

We don't say that site's picked out for any reason other than it was drawn to our attention in some of the submissions and it would appear to be a useful example of a situation in which a number of these issues that we've just touched on come together in a way which has produced an impact on the workforce there and it gives us an opportunity to have a little bit of a look at exactly how that might work in a practical sense.

Now, despite our best efforts to group the witnesses thematically, we've again been defeated by a fairly complex array of availability issues.

THE COMMISSIONER: That's fine.

MR MUSTON: It goes without saying that, to the greatest extent possible, we have sought to accommodate these and avoid any unnecessary disruption to the important work that various witnesses are doing, many of whom, as we speak, within the public health system. But hopefully, this slightly broader outline of the issues to be explored during this hearing will help contextualise the evidence given by the various witnesses as they come forward.

We can say that the Concord witnesses have, at least at this stage, usefully been grouped at the end.

THE COMMISSIONER: Okay.

MR MUSTON: It is the other earlier issues where we will be jumping around a little bit.

You should have a list of the witnesses we propose to call, which provides some indication of the timing and the order in which they will appear.

THE COMMISSIONER: I do, yes.

MR MUSTON: As always, no-one in the room should assume the timing is precise and it's given as an indication, but --

THE COMMISSIONER: So when it says "not sitting" Friday 26 July or Monday 29 July, first of all, that's reflecting an availability problem and enabling some preparation, is it - both?

MR MUSTON: It is in two parts. It's reflecting some availability issues; it's essentially attempting to avoid a situation where we all come in for potentially a very short burst of evidence from one witness who happens to be available, if they can be accommodated elsewhere.

THE COMMISSIONER: Am I right in assuming that when we finish on this Thursday, the 25th, if there was any spillover, it would be on Tuesday, the 30th, it won't be on Friday, the 26th. So we're definitely not sitting Friday, the 26th or Monday, the 29th?

MR MUSTON: That's correct. To the second part of your question, it's to enable, as best as possible, those sitting to my left to have a bit of time to consider the evidence in relation to the Concord case study, which, despite everyone's best efforts, as with the evidence in connection with these hearing blocks, does continue rolling in until quite late.

THE COMMISSIONER: Yes, and acknowledging that there is a certain amount of guesswork that goes into this schedule, other than the dates, but in terms of the timing, the expectation is that we will finish this block some time on Tuesday, the 6th?

MR MUSTON: Yes. We may finish on the Monday, but --

THE COMMISSIONER: More likely finish on the Monday than the Wednesday?

MR MUSTON: Yes, absolutely. To the extent that we have a half an hour to go on the Monday, we'll endeavour to sit long to avoid Mr Minns, who I think is the last witness, having to come back, but out of an abundance of caution we've had him drifting over into the Tuesday just in case.

THE COMMISSIONER: Thank you.

MR MUSTON: That brings us to I think the first of the witnesses that we're calling, Dr Dustin Halse, the division secretary (strategy research and projects) of the Health Services Union for New South Wales, ACT and Queensland.

<DUSTIN HALSE, sworn: [10.26am]

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Dr Halse, you are employed as the division secretary (strategy, research and projects) of the Health Services Union for New South Wales, ACT and Queensland?
A. Correct.

Q. That's a role I think you have held since 2023?
A. Correct.

Q. You have prepared a statement to assist the Inquiry with its work dated 15 July 2024?
A. Correct.

Q. Do you have a copy of that statement handy?
A. I do.

Q. To the best of your knowledge, are the contents of that statement true and correct?
A. To the best of my knowledge.

MR MUSTON: In the fullness of time, Commissioner, that statement will form part of the bulk tender. It is up on the screen but for the transcript it is [SCI.0011.0197.0001].

Q. Can I ask you to go --

THE COMMISSIONER: The bulk tender, you are referring to, is the 13 volumes of material on my left, is it?

MR MUSTON: I think, yes, I think the actual physical act of the bulk tender will probably be somewhat --

THE COMMISSIONER: Is the Dawson report of 1920 in that tender bundle?

MR MUSTON: That's going to get a special marking.

THE COMMISSIONER: It definitely will feature in the final report.

MR MUSTON: The bulk tender will, I think, as a practical matter, involve someone standing up before you and tendering the index to those volumes.

I should say, before we descend in Mr Halse's evidence, it is not intended that we will be taking you through in abundant detail during the next few weeks all of the documents in that 13 folders. There are aspects of it which create a useful library of documents which are relevant to workforce issues, including a welter of past reports.

THE COMMISSIONER: It is just that I noted you referring to a year 2000 report in your opening statement --

MR MUSTON: It is in there.

THE COMMISSIONER: -- which is a relatively modern report talking about the problems of health care funding.

MR MUSTON: There are several folders which contain the relevant awards. The key folders as far as the witnesses are concerned are probably the first three or four which contain a chronological list, the documents which are referred to by various people in their statements.

Q. Sorry, Doctor Halse. If I could take you to paragraph 4 of your statement, you tell us a little bit about the union, the HSU, and the in excess of 50,000 health workers it represents, and give us some indication of what they are not, in particular, they don't include nurse, midwives, members of the medical profession. What roles are typically held by members within the public

health system that are in your union?
A. It is an extensive response because outside of the medical fraternity, outside of nursing, there are literally hundreds of unique occupations that encompass what health work is in the public health system. So you think about allied health, for example, and the 23 unique bodies or groupings within allied health and the sub-groupings with those - everything from physiotherapy to clinical psychology, for example. And then there's the myriad of workers who work in the public health system that acquit all the responsibilities, from administrators to cleaning staff to food and laundry staff - all of the component parts that make a health system work. So I could not tell you the number of workers that we represent because it's literally hundreds, and that's reflective of the diversity of the workforce and what it takes to run a health system at a modern hospital in New South Wales.

Q. When you said a moment ago "literally hundreds", it's hundreds of different --
A. Categories, yes.

Q. -- classifications of roles within the health system?
A. Correct.

Q. Can I ask you to go down to paragraph 6. You see you indicate there a concern about the absence of an independent body or mechanism to capture real-time data on the health workforce, workforce vacancies and service demand. Can I ask you a series of questions about that. The first is: what is the data that you think could usefully be captured?
A. Can I premise this by saying that there is a trove of data that's already captured on the health workforce. Whether that's the national workforce dataset, whether that's the work of NSW Health stats, whether it's ABS data, ATO data, census data, there is a huge body of work done on capturing data.

HSU is of the opinion that there are gaps in the capturing of workforce-related data. I don't think it's just our opinion, but it's one that is reflected through the attitudes of our membership.

Q. What do you think those gaps are?
A. One of the critical areas is to capture data on workforce vacancies, current vacancies, how long there have

been staff vacancies and the willingness of workers particularly to work across the entire health system. Are they willing to work across regional or remote settings? So these are areas of data that our members have told us in the qualitative research that we've captured. It's also reflected in the Commonwealth Department of Health and Aged Care's reporting about data gap analysis - that we don't have enough data particularly on vacancies.

Q. So a moment ago you referred to data around the willingness of people to work, say, in rural and regional areas. Were you referring there to data about the particular motivations of individuals or rather data about that which is derived from something else - for example, vacancy rates within those locations?
A. We would suggest that it's an important dataset to capture the motivation and intention of workers to work across health systems.

Q. How do you think that could be done?
A. Well, it's a question that's been put by others. We think that there is a capacity to expand the data that's captured here in New South Wales. The methodologies in which you might engage to do that are relatively simple, but nevertheless extensive. It might be data capture techniques that emerge in both on-boarding or, a worker leaving a position within the health workforce, through survey, and both quantitative and qualitative work. It might be distilling down into some of the metrics that already exist and pulling out data from those metrics. It might also be the creation of a different mechanism within an existing body or a new independent body that can capture data that's relevant to - relevant for policymakers to make informed decisions.

Q. One of the challenges with capturing information or data around the motivations of particular individuals to work, say, in rural and regional areas, is potentially that the body of people who you would be seeking that information from might extend well beyond those already working in the public health system.
A. Correct.

Q. Would you agree with that?
A. Yes.

Q. So in terms of these what you perceive to be the data

gaps, the vacancy rates, the length of time that vacancies remain open and the motivations of people to work in different sectors or different parts of the health system, how do you think that information might productively be used?
A. Well, it's important to realise that for health system design, that data is a central point. It might be the first point in any systems design framework that's engaged or employed, because data informs or creates information which generates knowledge, which then translates to the ability for policymakers to make decisions which lead to actions which affect patients and workers across New South Wales.

We think that policymakers more broadly at times on certain questions might struggle to capture the data that is required to most accurately make decisions across a whole range of health policy questions.

Q. What leads you to that conclusion, that policymakers struggle to gather comprehensive data?
A. Well, firstly, we do see gaps in the data-capturing process. We don't have clear information on an integral question like workforce vacancies or staff vacancies.

We tendered a document to this Inquiry which was a GIPAA application recently, which pertained to NSW Ambulance, and when asking that body could they identify staff vacancies within that integral component of the New South Wales public health system, the response we received was "No data exists".

That, for us as an industrial body, as a trade union, is an alarming response. We would suggest that health policymakers would be advantaged by having access to real-time contemporaneous data on staff vacancies in order to inform decisions. If we're simply relying upon the existing national datasets and state datasets, they present good information on headcounts, they present good information on the number of a particular worker within a particular LHD or a location, but it might be - that's relevant to address a number of questions, but when we're talking about acquitting the responsibilities of the health service and meeting KPIs, the role of staff vacancies is hugely important.

Q. It's your belief that NSW Health doesn't have access

to real-time data on vacancies. What's that belief based on, other than the GIPAA example you've just given? Is that a particular reason that you held that belief?
A. I should note that that's one GIPAA example that we've obviously furnished to this Inquiry. That is wholly uncommon, as you might expect, for responses to be received in that fashion. I suspect, indeed I know, that we've got, as an organisation, a number of GIPAAs asking this exact same question to LHDs and others, and we await their response.

There's a theme there that has emerged, and again, without having that access to accurate data on vacancies, what it means is that groups like ourselves will have to identify gaps in the system, so it will be a delegate or an organiser who will identify that a particular hospital service is short-staffed by 25 cleaners, for example, and it will require the activism or the organising or the engagement of a trade union like ours to rectify an issue. It might require industrial action. A level of disputation that is inefficient, that might have been overcome if datasets were available to inform decision-makers or policy makers.

THE COMMISSIONER: Q. Can I just ask so that I understand, a number, particularly, of the regional LHDs have either, in the evidence we've gathered when we've gone to see them, or in their submissions, have said to us - and I'm generalising and not thinking of any particular LHD - "We have X number of vacancies for nursing staff and we've had those X number of vacancies for quite some time and it's a really difficult problem for us and we're having to use agency staff to get by, which is costing us a hell of a lot more money than it would if we had permanent staff in these vacant positions."

When you're talking about the issue you've raised in 6 of your statement that you've been discussing with Mr Muston, are you talking about a lack of a central database, or - and perhaps and - a lack of a good source of data in relation to the workers your union represents?
A. Probably both.

MR MUSTON: Q. Would you have any reason to doubt that NSW Health gathers information about, say, vacancy rates and the length of time that vacancies sit open in real-time but is simply not sharing that information with you?

A. That would be a question that you would have to put to them. In the tenor of the responses that --

Q. Just coming back to my question, we will be putting that question to them. My question for you is, do you have any reason to think that that is not a possible explanation for what you are seeing as a data gap?
A. We would contend that whether it's in direct discussions with a hospital's HR department, whether it's a formal application, GIPAA application, that there is a sense of obstructionist, or obstruction, that is sometimes picked up by our union in terms of being able to ascertain this data.

I suspect that much of it exists, as the Commissioner just referenced, talking to another LHD. There's a sense of vacancies. It's there, it's in the system, that information is there, but to our knowledge, it's not publicly available. It's not collated in a methodical manner that's presented to the public and provides confidence to the public with respect to the operation and the performance of a health service. We think that the more transparent, clear and accurate the data that can be presented, broadly to the community but also to health experts, policymakers, those in the political class, will aid in the design of more equitable and more accessible health systems and services.

Q. That picks up on something you have touched on in paragraph 8 of your statement, the public availability of the data. Is that a key feature of your complaint that the data that is retained by NSW Health or collected by NSW Health such as it might be is not shared publicly?
A. Correct.

Q. What information do you say should be shared publicly?
A. So we, again, distilling it back down to - and I'm conscious that there are hundreds of data points that you can collect across a system like NSW Health, but we think that absolutely, that capturing data on workplace vacancies, staff vacancies, on the time needed to fill those vacancies and breaking that question down, and then, as I mentioned, the capacity of workers or the intention of workers to potentially move beyond and to work in remote or regional settings, is a very important question for anyone in workforce planning, anyone in the ministerial wing who is responsible for health.

We would say that a consequence of a previous Special Commission of Inquiry 15 years ago was a very good recommendation, a bold recommendation, to create the Bureau of Health Information. That data is presented in a disinterested, unbiased manner, at quarterly intervals, as you will be aware, and it provokes discussion and debate within the community, within the press, within the halls of parliament. It's a tool that can be used to provide greater information and transparency about what's occurring within the New South Wales health system.

Q. So what would be the potential public benefit of having published, say, the number of vacancies in nursing staff in Broken Hill and the amount of time that those vacancies have been sitting open and unfilled? What do you perceive would be the public benefit of having that information out there for the purposes of debate?
A. In the feedback from our members, in accessing health services themselves, people want to have confidence that when they seek health services, there is a capacity to meet the particular needs that they have.

It should be the case that irrespective of your location throughout a state like New South Wales - and we know this not to be the case, through the data, indeed through the data captured through NSW Health stats. There are varying levels of health service that are offered to people based on where they might access that service or how they might access that service.

So we think that consumers of public health services have a right to be aware of effectively the health of that health service, how it is performing. We think that it's not just the public but it's the whole field of health policy, of labour - economists, of those who are engaged in that process of managing and commenting on the health system and how it operates here in New South Wales.

Q. Just picking up on your comment about the confidence that people need to have in the health system, is there not a risk that some publicly available information, for example, number of nursing vacancies in Broken Hill - I don't mean to pick on Broken Hill - and the amount of time that it has taken to fill them would erode confidence in that health system in a way which perhaps doesn't reflect reality?

A. It might also be a motivation for policymakers to address systemic issues.

Q. Like what?
A. Well, we're talking about the staff vacancies - to address those and to create or to try and explore methods, processes, to fill those vacancies, to provide a more optimal level of care.

THE COMMISSIONER: It's not like - when you say the amount of time that it's taken to fill them would erode confidence in the health system, it's not as though this is a complete secret, though, is it?

MR MUSTON: Is that a question for me?

THE COMMISSIONER: Well, it is an observation to you. I didn't quite understand the question but the witness answered it anyway.

MR MUSTON: The question perhaps - there is a further integer in the question, which is the fact that --

THE COMMISSIONER: The LHD management will know what the vacancies are; the doctors, the nurses, the other workers will have a general idea, and by dint of that, in a town like Broken Hill, many members of the public will know it to.

MR MUSTON: Perhaps I will put the question in a slightly different way.

Q. The fact that there is a vacancy which is unfilled doesn't necessarily mean that there is one less nurse on a shift or that there are any fewer nurses on a shift than is appropriate and required for the proper delivery of care, say, through the utilisation of overtime, agencies nurses and the like, as an example?
A. As an example, correct.

Q. So in that case, is there not a risk that by putting in an uncontextualised way information out there about nursing vacancies in a particular location runs the risk that people might think, "If I turn up at that hospital, I won't be confident in the care that I'm going to receive because they don't have enough nurses"?
A. No, we wouldn't - I wouldn't agree with that premise.

We do think that there is a set of questions that executives, that the ministry, needs to be held accountable to. We believe that if we were to survey the people across this state and ask them what type of information they would like about the health services in their region, in their backyard, how they are performing, how they are performing comparable to other health services, if they can acquit the responsibilities or the measures that are put in as KPIs, they would want to have access to that data.

It's not about undermining any area of health workers. I think it's broadly, if we think about the health workforce, there are few more trusted occupations than those who work in health within our community. That is a well-established data trend and research finding. It's not those individuals that are being targeted, and it's not being targeted, but it's providing information that will inform those in leadership positions that ultimately make these decisions, because people are not going to be - they're not going to - the response is not to question the role of health workers, it will be to potentially see how we can improve the system to make it more efficient so that those services can be met in a more complete way in whatever community that might be.

Q. But just seizing on the public availability of that information, at one level, decision-makers within health are capable of receiving and using that information in the way that you've just described, without it being part of a public dataset. Perhaps picking up on something you said a moment ago in terms of entities being able to hold those decision-makers to account, what would your organisation do with information that it received in relation to vacancy numbers and the period of time it takes to fill vacancies at a particular facility?

A. We would want to work collaboratively with the service. We would want to identify - just in walking down to this hearing today, one of our officials mentioned a scenario many years back, but where there was an identification of a huge number of cleaners, roles, that weren't filled at Westmead, and it took the agitation of the union to engage with that hospital and the executive of that hospital, to ensure that positions were filled at an expedited rate.

So it's not a case of, you know, this is a back door for trade unions to agitate for greater staff. We think

that there is - indeed, we know that all of the research suggests that we are in a difficult situation with respect to meeting the supply of health workers right across the system. It's felt across every LHD. It's more acute in some sectors of New South Wales, particularly those in regional or remote sectors. And we feel that absolutely, this type of data can be beneficial.

I might - and you might pull me up - note that, upon the establishment of the BHI, which releases some very sensitive data, data that health systems or health services might not ordinarily want in the public domain, with respect to surgical wait times, ED presentations, ambulance wait times, that data is presented in an unbiased and disinterested manner and it provides that wealth of knowledge.

Now, as a consequence of that body being established, have we seen an erosion of the confidence in the role of a NSW Ambulance worker? No, we haven't. People still avail themselves OF that service and the demand continues to increase. So we don't think that there's - there might be elements of this type of data capture that might be sensitive, but we think it's broadly in the public interest. We know that the Commonwealth Government, in that report I referenced before, thinks that this is a gap that should be made available, and we broadly think it will be a useful tool for the community but also for governance.

Q. I should probably just clarify one matter. Where you talk about "vacancies", are you talking about positions within an LHD which have been advertised and not filled?
A. Yes.

Q. So the vacancy that you refer to is not a debate about whether or not a particular facility is sufficiently staffed in circumstances where views might differ about that; it's where the LHD itself has made a decision, "We need another cleaner. We've put an ad out for that cleaner and we have not filled that position"?
A. At the base level, what our members are communicating to us is that it's a challenge to meet existing staff positions, let alone project into whatever expansion might be required into a particular health service. So just to ensure the current staffing levels that are attached to KPIs of that particular health service are being met with respect to that staff profile, that is particularly useful.

Q. You point to the lack of an independent body to capture this sort of data. Is it important that it is an independent body that is delivering this data, in your view?
A. Yes, and we think that, again, to cite the model of the BHI and how in its charter it proudly proclaims it's independence and its capacity to present data irrespective of - data without any interference.

Q. So is the BHI potentially a vehicle that could add to its existing datasets some further information over and above that which it reports on at the moment?
A. It could be, or a model like the BHI.

Q. Can I take you to paragraph 7 of your statement. Do you see at the very end of that paragraph you say that the existing NSW Health workforce ought to have a role in the capture of workforce data to ensure its accuracy and transparency?
A. Yes.

Q. What would that role be?
A. I think it's important we as an employee organisation - we think that it's always important, when you are talking about a health system, to capture the attitudes and opinions and the expertise of health workers. We might be concerned to a certain degree that not enough of the feedback of our health workers, those who are directly engaged in the provision of health services to members of the New South Wales community, are not captured. We appreciate that the Public Service Commission does its "People Matters" report and particularly along cultural lines and a cultural understanding of the particular area of the public service, capture very good data and huge datasets, which are again reported, debated in a range of different forums, but what our members tell us is that they would like to be more engaged at the local level, particularly, but also at a statewide level, in presenting their feedback, their information, into that policy-making process.

Q. What might that look like? Is it a survey of health workforce or speaking forums where people are entitled to come and express their views and grievances about their workplace? What do you have in mind in terms of the particular role?

A. A whole range of methodologies, including surveys, direct interviews, focus groups, standing committees, to feed into certain processes. We were interested recently in going through the 2022-2032 NSW Health workforce strategy document to see that, in the supplemental guide to that document, a link to a workforce consultation that occurred statewide that only included 126 workers of the health workforce, for a system that's worth $33 billion a year.

Now, I'm not suggesting that's the only bit of workforce data captured, but to inform that report that's publicly available, the 10-year plan for NSW Health, we don't see any linked data that captures more than this workforce snapshot that they have produced. It might be emblematic of the way in which workers are engaged and consulted in processes that directly impact them and in which workers are best placed to speak about a whole range of issues, irrespective of the knowledge and the capacity of those who might sit in senior executive positions but we think that if we want to design a health - a more equitable health workforce, that workers have to be central to that process and invited to be in that process.

Q. So is this a workforce planning tool, that is, the input that you say will be received from the existing workforce, or is it more a tool which is to be used for service delivery, planning and decision-making?
A. Well, health is dynamic, isn't it? It changes daily, weekly. I don't think it necessarily needs to be either one or the other.

Q. I'm just trying to get a little bit of a handle on exactly what information would be fed up through the workforce to inform what sort of decisions?
A. Yes, and I would point you to the workforce consultation paper that informed the 10-year New South Wales plan and the type of work that they have done, which was informed by an external consultancy, but we think there's a range of questions that health workers can talk into. It's about the current state of their place of location - everything from infrastructure in that setting, everything from skills mix in that setting, everything from particular practices and policies that have been implemented in that setting.

I'm conscious that they are best placed to inform us

and inform others as to the type of models and the type of practices that best support and enable optimal health care.

Q. In the context of a devolved system where a lot of these decisions are being made, say, in a facility or potentially even in a department, is it not possible that a lot of that information around, for example, skills mix, to pick up on one of your examples, is not already being discussed and debated within a department and informing decision-making in that department about the skill mix that they should best adopt for the purpose of delivering care?
A. Yes, and again I'm not suggesting that none of that work exists. That's not the testimony I'm providing. There are consultative committees at the local level, in the department level, across LHDs, right through to the broader whole-system level. I'm simply relying upon the attitudes and the feedback that our members have responded to the research work that we have conducted in which, universally, they want to be more engaged in processes.

So it might be the process itself is not - is inadequate; the process might not be as comprehensive as it otherwise would be; it might not give health workers the opportunity or the agency to talk into matters that they want to talk into; it might be controlled or contained in a manner that is set by individuals who don't work in that particular department or who have no knowledge of a particular health - the duties or responsibilities of a particular health professional.

All of those things have been reflected to us, that we want to be more engaged because we have a wealth of information and data that we can impart. And what that looks like we don't have a perfect template, but what we can translate is that that's what they're saying, not 100, not 200, but thousands of workers.

Q. In a good workplace which is well managed, decisions are made collaboratively, these sorts of issues won't be a problem, presumably - that is, you are unlikely to have your members complaining about a lack of consultation in a workplace where they are being consulted?
A. That's a reasonable statement.

Q. Would it be fair to say that there probably are a lot of departments and particular units in the wide and devolved system that is NSW Health which are actually

functioning well in that respect?
A. Yes, and again, that's a fair assumption but it doesn't stray away or it doesn't diminish the point that, en masse, there are thousands of health workers who we have spoken to, discussed, these people who are right across that unique occupational list, who have expressed to us that that consultation is either incomplete, that it's not as extensive as it could be, and that they have information, they have data, they have knowledge and passion and commitment that they can feed into a process - not an adversarial process but a process to improve health services. These are passionate health workers. We represent tens of thousands of them across this state and they have a skill set and a knowledge and they rock up as health workers because they care about the provision of services that they can provide to patients.

Q. Sometimes, even where there is adequate consultation, decisions will be made which don't line up with what the particular health workers who are consulted think should happen?
A. Mmm.

Q. Would you agree with that?
A. That's an accurate comment.

Q. And sometimes, that might, at least in the minds of those health workers, manifest itself as an impression, "We have not been listened to or adequately consulted with"?
A. Yes.

Q. And so teasing out which side of that line, the particular feedback that you have received from your members is something which is never going to be particularly easy, is it?
A. There will always be a contest. That's the nature of the work that we perform as a trade union. Again, we would simply reflect that we - alongside other health workers, that we are the workforce, our members are the health workforce.

Q. In relation to the consultation, you don't - or do you - suggest that there should be some centrally administered policy that deals with the way in which the health workforce is to be consulted on the no doubt wide array of different issues that crop up in all of the different departments across the health system, or is it

more you think that it should just be done better locally? A. More so the latter, that it should be a more robust process that engages with health workers, that gives agency to their voice and expertise.

THE COMMISSIONER: Can I just make an observation - and this isn't for you, Dr Halse - that might assist you and also Mr Cheney and Mr Chiu on this topic. I've just, first of all, satisfied myself again as the evidence is being given that we are well and truly in the terms of reference, and there are - because we have to inquire into, amongst other things, shortages of workers and particular skill sets in any location. To inquire into that, we obviously need data and facts.

Those representing health might eventually tell me, and I, sitting here, just don't know, that all of this data is available for vacancies, for example, somewhere - maybe not in a centralised spot but various places. But if it's not, it would be good if either through Dr Halse, or some other witness or witnesses, I was convinced that it was a good thing that all this data be publicly available, but I'm not sure they have to convince me of that. I mean, this is a public health system, and if there are vacancies for any particular position, I think I'd have to be convinced there is a really bad reason for making that public, because otherwise, it doesn't seem to me that this sort of area we're discussing ought to be a state secret. We ought to know - that is, everyone, every citizen of New South Wales ought to be able to know - I would have thought, what the vacancy rates are for particular positions in the public medical workforce, regardless of the position.

There's a lot of stuff that government keeps secret that there is an arguable case there is no good reason other than a political one for it being kept secret from us, but it would be nice to know that there would be a good reason - and there might well be some good reasons - for this information being public, but I don't even know that I need to be convinced about that. If it is not, it probably ought to be, because it's not a state secret.

But I'm also conscious that I might be told, and as I said, sitting here I am a bit ignorant about what the data actually is, but we're obviously going need it to answer that terms of reference. I don't know whether that

helps or not but I will just leave it there.

MR MUSTON: I think Mr Thompson's report reveals a great deal about what data is actually available. When I say "available", I mean available to the ministry.

THE COMMISSIONER: Yes, true.

MR MUSTON: Q. Could I ask you, Dr Halse, to go to paragraph 9 of your statement. This is just to clear up a matter of semantics, but you refer in that first sentence to a widespread and current labour crunch across all parts of the New South Wales public health system. For my benefit at least, what are you referring to as a "labour crunch"?
A. I could have amended that, a labour shortage; a challenge to supply.

Q. More jobs than there are people to fill them or willing to take them?
A. Yes.

Q. What do you think the causes of that labour crunch are or that shortage?
A. A whole range of reasons - the capacity of the training system, the health training systems in Australia to provide adequate numbers and train adequate numbers of health workers right across the system. I think it is a universally accepted finding that we're struggling to keep pace with the number of health workers we require.

It would also go to the competitive nature of health care. Health care is not just a domestic market; it is an international market as well. It goes to the opportunity cost of workers that can work in other sectors of the economy that have superior wages or settings - wage settings or conditions of work and they elect to work in those industries as opposed to pursuing a course of action to undertake study in a health field. So a multifaceted challenge to meet demand.

There is also domestic competition for health workers, and we've seen this, and again through the focus group work of our research at HSU, indications of workers, not huge amounts but an indication, this theme emerging, that "If I can jump over the border into a different jurisdiction, almost automatically, I can earn a higher rate of pay or

a different set of conditions that might suit me. So a whole range of factors. They're just a few.

Q. Just in relation to that last factor, is the sense you get from your dealings with your members that that jumping over the border for higher pay in a particular discipline is something which extends to a great degree beyond those living in border regions?
A. Most likely not those who are extending outside of those border towns or those border regions, but it is something that has been frequently articulated to us as union officials. It was writ large during the recent paramedics pay dispute with the New South Wales Government when paramedics universally identified the different rates of pay and different conditions between particularly Victoria and Queensland and here, the conditions that they were receiving in New South Wales, but particularly focused on those border regions where there is a capacity to move up and down between jurisdictions.

Q. So using that paramedic example, if you've got people who are living up near the Queensland border, is it the feedback that you have received from your members that they will drive that extra little bit to cross the border and work as a paramedic in Queensland where they might be able to get paid more?
A. Well, prior to the historic intergenerational wage increase that has just been negotiated for paramedics here in New South Wales, that was clear feedback that was received by the union.

Q. In terms of those who are not living in a border area either to the north or to the south, you said feedback was routinely received from members about the pay disparity, but was the feedback that you were receiving suggesting that that pay disparity was causing a significant number of people who were not living in those border areas, say someone who was living in Sydney, to up stumps and move to a different jurisdiction altogether to work or was it more just a source of an increasing source of irritation and unhappiness within the workforce in New South Wales?
A. I don't want to over-egg the situation or the response. It definitely was a live discussion from members within the service. Obviously, those who had the capacity to move across jurisdictions more easily, it was a very real consideration. For those who were domiciled in a central location where it wasn't as - you weren't as able

to do so, I suspect it's a logical conclusion that it wasn't as strongly felt, but it was a live discussion right throughout that paramedic wage dispute.

Q. Could I ask you, in paragraph 10 you tell us about the Reform Critical Report, and in particular, the outputs of some modelling that was done. I don't intend this critically in any way, but the modelling which is done obviously is built around a range of assumptions which build or form the model; would that be right?
A. Yes.

Q. Is there anywhere where those assumptions, or the assumptions which underpin the model, are publicly available or could be made available to the Inquiry?
A. So the Commission has the report in annexure 2, I think, there is the modelling framework that Dr Angela Jackson put together to come to this set of figures.

Q. Perhaps it is my poor understanding of it, but does the framework articulate clearly all of the assumptions which have been made in the model?
A. The model that she has prepared indicates the type of datasets that have been relied upon, so the assumptions. It's an extrapolation of a whole range of datasets, particularly with respect to population data, ABS data, a whole range of other areas of data. I'm happy to get it out and go through it, but this is a model that she has come up with, and it might indicate again the contested nature of workforce projections, that Dr Angela Jackson, a senior health economist in this country, who has just been leading the federal government's COVID-19 inquiry, and her team have produced these figures, there might be other figures housed within other sections of the public service, and it might go to the contestability of the current situation.

It goes back to what we think is the importance of having foundations right and data - it might sound a bit repetitive here, but data is the one thing that you can capture in the full extent, in the comprehensive extent, that can truly inform policymakers.

Q. So whilst potentially contestable in terms of the assumptions you make and the methodology you apply, your ultimate point is really that decisions should be made based on some sort of a hard foundation of data, not just

reacting to a situation that might emerge --
A. Absolutely.

Q. -- at any particular point in time?
A. And I'm reluctant to bring this up, but most acutely, in my work experience, the absence of data can have huge ramifications on health systems. We saw that most acutely - and I don't want to trigger trauma for anyone - but through the COVID-19 crisis, the acute phase of that, where policymakers, politicians, senior executives, hospitals, were trying to engage in a decision-making process without complete data because some of that didn't exist or that it hadn't been captured.

Q. In paragraph 13 of your statement you express some views about the nature of the collaboration between NSW Health and the HSU. Without wanting to traverse what you consider to be the current state of that collaboration, what do you think would be a good way for your union and NSW Health to be collaborating productively? How do you think the relationship should work to produce positive outcomes?
A. We think that - I mean, you might not want me to talk about the specific application here, but we think that it's a wholly reasonable application to make on a critical area of NSW Health, in NSW Ambulance, to be aware of staff vacancies. We think that a collaborative model might be to have data available, existing data that is tracked, that is evaluated, that is monitored, available to not just the HSU but other groups within the community who might find it useful, for us to be able to access that data and to engage on the back of that data with health services or, sections of the health service, as opposed to always going through a process, through freedom of information, GIPAA, et cetera, to ascertain an accurate picture of a particular issue that we are seeking to address.

Q. It's always going to be a challenge, isn't it? in what I think you observed a moment ago is often contested space, organisations like yours will often be in contest with the ministry in relation to the making of decisions and the like. Does that contested nature of your respective roles in the broader ecosystem run against the possibility of meaningful collaboration?
A. No, I wouldn't accept that universally. I think that there are areas in which industrial bodies, employee representations, can work very constructively with

employers and --

Q. In examples that you have of where that has happened, what is it about those that - the relationship, which has been so successful?
A. I think there is an openness - there are cultural dimensions. Culture is very difficult to measure, but there is an openness to partner with groups like the HSU to address a particular problem and a willingness to reach out, to talk to not only our members but our officials, to find pathways to move forward to address particular issues.

Often, that is not the case. Often, it is a case of, you know, we'd like to know, we think it's relevant that we should know, the number of vacancies across NSW Ambulance. We might have a contribution to make in that space because we represent those paramedics. We might have a range of solutions or ideas that could be implemented, but we can't even get beyond that juncture of, "Can you please just tell us how many staff vacancies exist?"

So the process from the beginning can be adversarial, and that, that culture that might focus on that or might have elements of being adversarial as opposed to being collaborative or working in partnership - we will always advocate for our members to receive fair pay and fair conditions of work, and that will always put us, to a certain degree, in contest with governments and with others, with employer groups.

But that's not to say that just because of that, that we can't collaborate or partner with elements of the health service every single day on unique issues in which our feedback should be imperative to providing solutions. We would think that it's a logical conclusion to make that if you've got staff shortages or vacancies within NSW Ambulance, that you would ask the union that represents ambulance members and ask directly for their feedback and how they may have unique insights to overcome particular problems. That's just one example of obviously a plethora that emerge throughout NSW Health.

Q. In terms of consulting with members, you tell us in paragraph 14 about a survey that the HSU conducted recently of its membership, raising some of the issues addressed in the Inquiry's Issues Paper 1/2024. I think you have now had an opportunity to collate some responses to that

survey. Can I provide a copy of a document headed "HSU Special Report - A NSW Health Workforce at Breaking Point", to you.
A. Thank you.

MR MUSTON: I will provide a copy to the Commissioner as well.

THE COMMISSIONER: Just before you go on to that, you asked the witness some questions about the reform critical "fragmented health system at breaking point" report prepared by Impact Economics. Is that in the tender bundle?

MR MUSTON: It is.

THE COMMISSIONER: Right. Okay. I mean, that report - I mean, the questions you asked about that report and particularly the assumptions regarding the modelling, what ultimately is made of that report we will see, but in terms of its big-picture findings, such as the spend on health is growing at a rate that's higher than other areas of public expenditure, that the percentage of the budget dedicated to health spending is rising and that unless we get some progress on the number of years that people spend, for example, in chronic disease at an acute level, that that expenditure on health is going to continue to grow, perhaps unsustainably - all of those things that you can take out of the report, whether the exact figures are one way or another, they're all consistent with a myriad of other reports, including government reports themselves, aren't they?

MR MUSTON: That's absolutely right. I don't want to over-emphasise or unintentionally over-emphasise the point around the modelling but I was more concerned with the precise numbers which have been repeated in Dr Halse's statement, that - for example, just looking at the penultimate line of paragraph 10, the 41,800 nurses, 19,400 diagnostic and allied health professionals. As to the way one reaches those particular numbers, I think Dr Halse --

THE COMMISSIONER: It would be a stretch to make a particular finding about those numbers based only on the reform critical. My point was that in terms of what you'd call perhaps generalisations but big-picture challenges, the report's conclusions are consistent with many other

reports, including intergenerational reports, Commonwealth and state.

MR MUSTON: My learned friend Mr Cheney might tell you otherwise but I don't anticipate there is going to be any dispute about the proposition that without adjustment, the cost of delivering health care is going to continue to increase as we move forward.

At one level, important considerations of this Inquiry are what systemic adjustments might potentially be made to try and control that. I don't think it's realistic to think it can be avoided. But there needs ideally to be control to enable the health system to function both practically and in a manner which is economically viable.

THE COMMISSIONER: Yes. Unhelpfully or not, I've interrupted again, but I'm wondering if my interruption is a good time to take the morning tea break.

MR MUSTON: I think that will be an excellent time.

THE COMMISSIONER: I have just noticed a moment ago - it may be that there is a more updated version of this - the witness list I've got has Dr Halse at 10 but it's got Ms Annette Solman and Dr Josephine Burnand also at 10. That's obviously a typo. I know they follow this witness, but there is also Professor Twigg on the list for today. Are we going to get through all these witnesses today?

MR MUSTON: I think we will. In terms of them being listed at 10, I think the Inquiry team was trying to avoid a situation where hard and fast times were given, because we end up with gaps.

THE COMMISSIONER: I see, that's fine. So that people weren't online, for example. Okay. We'll a take a break until 10 to 12.

MR MUSTON: Before we do that, can we mark for identification the document --

THE COMMISSIONER: I have no idea what MFI we are up to.

MR MUSTON: MFI 10.

THE COMMISSIONER: HSU Special Report "A NSW Health

Workforce at Breaking Point". What's the date of this?

MR MUSTON: I don't know whether it has a date.

THE COMMISSIONER: We will just call it that. MFI 10.

MFI #10 HSU SPECIAL REPORT "A NSW HEALTH WORKFORCE AT BREAKING POINT" BARCODED [SCI.0011.0266.0001]

MR MUSTON: Just to finish on that.

Q. The document that has just been marked MFI 10, are we correct in our assumption that this is a collation by the Health Services Union of the responses received to the survey which is referred to in paragraph 14 of your statement?
A. Correct.

THE COMMISSIONER: Thank you. 11.50.

SHORT ADJOURNMENT

THE COMMISSIONER: Yes, please go ahead.

MR MUSTON: Q. Dr Halse, shortly before the break you were telling us about some of the challenges that are presented in terms of addressing workforce shortages, and one of them that you identified was the ability of training institutions to produce graduates in these various disciplines, something you touched on in paragraph 16 of your statement?
A. Correct.

Q. Just in relation to that, what are the observations, what sorts of observations, have been made by members which have led you to reach the conclusion that you've expressed in the first sentence there of paragraph 16.
A. They are - many members have expressed to us that they are experiencing what they may consider a shortage within a particular department or work setting with respect to the number of particular health professionals in that setting or general or public health members. So that's borne out of that observation, and again that's quite a universal observation, that to varying extents across the system, but a huge proportion of our membership are indicating that there are shortages of staff and that includes allied health staff who require more formal processes of training.

Q. Is there in addition in particular about those observations around staff shortages which led you to the conclusion that you have expressed there, that it's the training institutions that are not able to produce enough graduates or provide an adequate supply, recognising that there is a connection between the two, but anything in particular that has been passed on to you about the capacity of institutions to produce graduates?
A. It's a reflection of the growing demand in the system and in the sector, the exponential demand for health services right across all of the sectors of health, and our members are saying quite clearly to us that there are - the gaps in the workforce continue to exist irrespective of the current training output from the university or the vocational sector.

Q. In the last sentence you refer to the time it takes to obtain qualifications and, in some cases, the need to obtain postgraduate qualifications to practise. Just so I can understand your position in relation to that, do you suggest that anything should be changed about that? Is it your position that the time it takes, say, for a physiotherapist to qualify as a physiotherapist should or could sensibly be reduced in any way, just as an example?
A. I don't think I'm best skilled to respond to that question. I know many of our members would be. It is a reflection, however, that many of our members have postgraduate level qualifications that require four, five, six-plus years of training, clinical training, and that's a significant investment for the health system, it's a significant commitment for them as individual workers. If it's not planned or projected accurately, you can very quickly find yourself in a position in which there is a workforce challenge to meet demand.

Q. Just tracking down to the next issue that you raise in paragraph 17, which relates to the clinical placements and the need for clinical placements to be made available as part of the training of the future workforce, you allude to what is described as "a lack of coordination between local health districts and education institutions" as one of the concerns that you have about the access to training clinical placement positions. What is your understanding of the existing arrangements that exist - existing arrangements between LHDs and training organisations?
A. What we've been told through our members is that there

is real challenge and complexity in marrying up the role of the education provider and the services that are provided within a health setting. Central to that are clinical educators.

In discussion with an associate professor of clinical psychology the other day, a HSU member, noted that that's a unique position to acquit within the health service - that we're not training enough of those individuals, in her estimation, and that directly impacts that whole chain of the capacity to get workers into the system.

As noted, members have also indicated that as we expand, particularly allied health services, as new services that 20, 30, 40 years ago did not exist come on line and become a central part of health care, that there are both physical infrastructure needs within hospital settings or health settings, but there are also human capital needs that are required to meet that demand.

Q. Just looking at each of them, the physical infrastructure, for example, you need sufficient desks and computers for the clinical placement students to be able to come in and participate in the workforce to the extent that they need to participate in order to have a meaningful clinical placement - that no doubt varies from one discipline to another, but that's what you are referring to as your sort of physical constraints?
A. Correct.

Q. In terms of the number of suitably qualified people available to supervise students is to the point that you made a moment ago, that if there are shortages of particular skill sets within a workforce, then that will not only result in sufficient people potentially to deliver care in those areas but also reduces the number of people who can provide supervision for the next generation of workers within that particular discipline?
A. Correct.

Q. What I want to ask you about is the first of the points that you allude to, though, which is the coordination between local health districts and educational institutions. Have you had any particular discussions or engagement with either LHDs or educational institutions which have informed your understanding of what the current nature of collaboration between those two entities or

groups of entities is in terms of harvesting as many clinical placement positions and providing them to students as is possible?
A. So this is more feedback that we've gained through focus group work and direct interviews with our members as opposed to direct feedback or conversation with education providers, to link those two, but it is a clear area of feedback for our members, and we note that recently, the Australian College of Deans of Health Science noted that clinical supervision is one of the huge problems within particularly allied health care, and they list a myriad of issues that the sector, the 23-plus unique professions or groupings, encounter.

One of the reasons that a HSU member put to me the other day is that in health professions outside of medicine and outside of nursing and midwifery, there is not the scale, and there hasn't been often in the history, because of the development of some of these industries, so they're playing catch-up with respect to the manner in which infrastructure, both physical and human, is made available and it's applicable to that cohort of workers, and it's a reflection of the emerging nature of health care.

Q. Just coming back to that point, though, has any particular observation or repeated observation been made to you by members which criticises or identifies a particular flaw in the collaboration between LHDs and educational institutions insofar as that collaboration occurs at the moment?
A. Apart from a general comment, not that I can pinpoint.

Q. Could I ask you to go to paragraph 19 of your statement. You refer there to the lack of paid placements. I think the Commission has heard a lot about the concept of placement poverty and understands what you are addressing there, but I just want to ask you about the next issue you identify, which is the lack of structural programs to enter into allied health professionals - what are the structural programs that you have in mind there?
A. Well, it is a reflection of, number one, a lack of clinical placements. So there are structured programs across all of the various health profession areas.

Q. Just pausing there, a structured program, when you allude to that term there, are you talking about there is a structured program of study, at a particular university,

at the end of which you could become, say, a professional physiotherapist?
A. That's correct, and there will be that collaboration between the education provider or trainer and the health system to provide the capacity to train those health professionals.

Q. And so, again, if the structured program that you are alluding to there in paragraph 19 is that structured program of study being delivered by a particular institution, is your point that there are not enough student places available within institutions at the end of which is a qualification as an allied health professional of some particular description?
A. Yes, there's a challenge to meet the current demands. When we have a rapidly growing complement of allied health workers that needs to meet that exponential demand, it requires that mirroring within that clinical placement experience, and what our members have demonstrated to us, or portrayed to us, is that it is growing so rapidly that they are concerned that we cannot meet the pace of demand; that if we increase university places, which is necessary, we also need to ensure that there is that infrastructure available to train these health professionals.

We are concerned, as you reference, that the federal government recently has announced that some areas of health care will be supported through clinical placements but not allied health professionals. That's again a real challenge that involves levels of government and training institutions, and in an era in which we cannot afford to lose too many health workers, that we are again deprioritising, to a certain degree, knowing the budget constraints and that there are finite resources available, but we would advocate passionately that they are more completely drawn into that health landscape.

Q. Maybe going back to something we were discussing before the break, but in paragraph 20 you tell us that the HSU considers, based on what it is told by members, that recruitment within the New South Wales public health sector is reactive and not proactive. What do you mean by that, in a practical sense?
A. It is an observation that is drawn from the huge number, from a percentage wise, of our members who indicate that there are, to go back to our previous line, staff vacancies within departments, and the common response we

hear from members is, "We have just filled a vacancy, another one has emerged." "We haven't planned that someone is retiring, someone is intending to leave the workforce - no-one was aware of that", because we don't capture really good data, it goes back to that central question of data. We don't have that information. And then health services, doing a wonderful job as administrators who we represent, are trying to plug gaps within a particular department to acquit the duties.

So as a statement, I have seldom met a health worker who said, "We are over prescribed, that we have a large contingency of workers in this department who are permanently engaged so that if there is an escalation in demand that we need to meet or if individuals, for whatever reason, leave the service, we can immediately or quite easily meet that demand." In my experience, I've not - I'm not sure I've met a health worker who would say that.

Q. In paragraph 22 you tell us about concerns raised by your members about the time that the recruitment process takes within NSW Health. Could you be a little bit more specific about the particular concerns which have been raised with you on that topic?
A. Yes. Of course, unlike other occupational groupings or industries, to fill placements within the health service is quite important. If you don't have enough cleaning and administrative staff, the surgical wards can't operate. So it's been reflected to us that it often takes too long to fill existing vacancies, and there might be - there would be a myriad of reasons for that.

One reason that was cited to me recently by a HSU official was the time it took to complete a criminal record check, and if it's taking multiple weeks or longer to perform that function, then you can't fill a spot, whatever it is, within a health service. Then again, it goes back to that sort of relationship that groups like ours have with the health service, that we need to engage in a more adversarial approach to ensure that existing vacancies are met. So that's a small little example of how, for example, the recruitment process might be expedited.

But the simple premise being that, in health services, often it's paramount to be expeditious in the recruitment to fill gaps, otherwise those departments, that provision of health care, cannot be met.

Q. Could I ask you to go over to paragraph 24 of your statement. You acknowledge the need for flexibility through a temporary workforce but express concern about the dependence in New South Wales on temporary staff, such as VMOs, locums and agency staff. I think we understand the issues insofar as they apply to locums and agency staff, but could I ask you to explain what your particular concern is with respect to visiting medical officers?
A. So we have as a central argument that we believe a permanently domiciled workforce provides the level of continuity of care that provides optimal patient outcomes. We think that that's quite clearly demonstrated in some of the research that is publicly available, external research.

When we compare - and this is a finding through our research report "Reform Critical", when we compare the New South Wales jurisdiction compared to Victoria and Queensland, we observe a much higher level of VMOs and the use of VMOs. We're not suggesting that they don't perform excellent work, but what we're suggesting is that there might be some structural elements within NSW Health that prioritise VMOs over permanency, which may not lead to more optimal care for patients.

Q. Do you have a view about what those structural issues might be or a little bit beyond your remit?
A. That might be slightly beyond my remit.

Q. Could I ask you to go down to the final paragraph, paragraph 27 of your statement, where you indicate that the HSU considers that many NSW Health worker awards are outdated and require modernisation. Do you have any particular examples that you think illustrate that point well?
A. We know that there's a current process of award modernisation occurring in New South Wales. We support that process, and our members across a whole range of professions are deeply involved in that. But to give you one clear example, there are some members, health workers, who are not captured by the current award structure. So a mental health peer support worker is not captured within the current award structure.

Q. So how are they employed currently?
A. My understanding is that they are employed as a health education officer - I can double-check that - but it is

a demonstration of the development and the dynamism of health that it's always moving, it's always evolving, always changing, and that the award structure has often been playing catch-up to the roles and the functions that our members perform.

Q. In terms of award reform, what do you think that might look like as a process, for it to be effective? Are we talking about a log of claims where things are debated in relation to the existing awards or is it your view that a different process should be embarked upon which essentially commences with a blank sheet of paper?
A. Well, that process is under way, it's commencing, we're involved in submitting logs of claims and working with the relevant areas to ensure that the settings within an award - everything from pay and wages and the conditions under which workers are engaged and the skill sets and the level of professionalisation which can be observed within an award structure - is being observed. Simply because if these processes aren't undertaken repeatedly and often, as I said, given the nature of the health workforce, there are elements that will be missed.

What our members are saying to us is that there are elements of our scope of practice, there are elements of the work that we do every day that's just not captured in the current awards, so we'll go through that process with government and ensure that it's more reflective of the current workforce that we have, let alone the projection of what the workforce might look like in 15 or 20 years' time.

THE COMMISSIONER: Q. It might be captured in the answer you've just given, and I understand your answer. I think Mr Muston's question was more fundamental, in the sense that what he was asking was whether the awards as they are - whether you've got a log of claims or you're amending the current awards, or whether a better process would be just to start anew?
A. Yes --

Q. His wording was a blank piece of paper?
A. A blank piece of paper. And there is that process of streamlining, where there is a capacity to streamline awards, make them clearer, make them more reflective of the current nature of work, that's the intent of HSU to participate in that program, to ensure that we don't have awards that are outdated, that are not applicable, so to

ensure that they are modern, they are relevant, they are capturing all the things that members require.

Q. So either way, we're not looking at minor amendments or tinkering. It's a fundamental process?
A. A fundamental change to the structure is required.

MR MUSTON: Q. What do you anticipate the timing of that exercise will be? When will it concluded?

THE COMMISSIONER: We'll have to ask upstairs.

THE WITNESS: You might have to. You might have to. Our members have prepared huge amounts of - huge troves of research informed by internal workforce committees, presenting claims, engaged in that process of negotiation, are fully participating in a collaborative way in a process to ensure that we have a structure that sets up, that is responsive and reflective for not only the current workforce but potentially can anticipate some of the challenges that will confront the future.

So it is not an easy process. Any award reform process in any sector, whether it's health or otherwise, can be complex, it can be laborious, but it's very clear that in health particularly, given again the rapid changes in the nature of work, that the structure is out of date, it needs to be not tinkered, it needs to engage in a process of wholesale reform.

Q. Do you think there would be any benefit in setting a sunset date for that award reform process to focus people's minds on achieving reform as quickly as is reasonably practicable?
A. Any mechanism that can reasonably expedite a process and meet the concerns of those negotiating parties, all negotiating parties, would be a reasonable conclusion to draw.

MR MUSTON: I have no further questions for this witness, Commissioner.

THE COMMISSIONER: Can I just ask, though, how should I understand that last question about a sunset date? Is that some sort of legislative sunset date?

MR MUSTON: Yes.

THE COMMISSIONER: Q. Did you understand it that way?
A. I did, yes.

MR MUSTON: Q. I should ask this question: are you aware of legislative sunset dates of that type having been utilised as a tool in other jurisdictions in the context of the award reform processes?
A. It's a good question. Off the top of my head I can't pinpoint one but it would be wholly unremarkable.

MR MUSTON: Thank you, Commissioner.

THE COMMISSIONER: Thank you. Mr Cheney, do you have any questions?

MR CHENEY: Yes, Commissioner.

<EXAMINATION BY MR CHENEY:

MR CHENEY: Q. Sir, could I ask you first about something you said quite late in your evidence about the, first of all, the lament, I think, in paragraph 27 of your statement that many health awards are outdated and require organisation - I think you understand that to be an observation that's shared by NSW Health?
A. Correct.

Q. You've gleaned that perception from your dealings with NSW Health about award amendment?
A. That's a common reflection within our organisation.

THE COMMISSIONER: That's the Inquiry's understanding, too.

MR CHENEY: Yes.

Q. You were asked some questions, in a different context, about HSU's desire to be collaborative and you were asked what you perceive to be the benefits of such collaboration and that different context related, I think, to staffing arrangements, but you recognise that collaboration is needed also on this question of award modernisation?
A. Yes.

Q. And you would have perceived, I gather, that there are aspects of outdated awards that impede the efficient

delivery of health care?
A. Correct.

Q. That need to be modernised or changed?
A. Correct.

Q. Sir, you've spoken about the perceived benefits of an independent body that might capture what you describe as "real-time data". I just wasn't clear what you had in mind by that phrase "real-time data", if you can help us?
A. Yeah, sure. So it might be considered as contemporaneous data. So that might be, for example, a dataset that's captured over the course of the year with multiple intervals, a little bit like what the BHI captures, so quarterly data that might be considered real-time data. It's not historic, it's not from the last financial year, it's not from multiple years ago, but captures as, a course of its work, repeated data. How quickly you might be able to capture that data is a question, but a model is there, obviously, in a different context, with the work of the BHI. But we think that for data to be most powerful, it should be contemporaneous and real-time, and again, I'm stressing this point, the change is often required rapidly within health so that real-time data can inform policymakers.

Q. But by real-time data you're not contemplating, for example, daily or weekly or even monthly reports from various LHDs about vacancy rates?
A. It might be difficult on a daily schedule, but --

THE COMMISSIONER: It might not be particularly useful either.

THE WITNESS: I'm not sure it would be either. But within reasonable - a reasonable time frame that might be considered real-time or contemporaneous, valid, current data is the point we're trying to get to, so it's not a finding from 15 months ago. Someone can confidently say that within two months or six weeks or three months, that this is an accurate picture of what might be occurring in the section within the health service.

Q. And I think in an answer you gave quite early on you observed that there's already a - I think you used the term - "trove" of data available to the public, including your union, obviously enough?

A. Correct. And we use that, we observe it, we use it and it's very helpful.

Q. And you cited, I think, as sources of such data the ABS, the ATO, the census and NSW Health statistics?
A. Yes, and the National Health Workforce Dataset.

Q. And in addition, you might also cite, I suppose, the Australian Health Practitioner Registration Agency data?
A. Correct.

Q. The Australian Institute of Health and Welfare data?
A. Correct.

Q. The Independent Health and Aged Care Pricing Authority's data?
A. Correct.

Q. And various other Commonwealth Government agencies?
A. That's right.

Q. So is your real objective to have a process for assimilating all that data or presenting it in one coherent form?
A. That has been put by health experts and academics and researchers more broadly, who are analysing the Australian health system or a particular jurisdictional health system. It's not simply that, in a number of the areas we're seeking an expansion of the data. But anything that can collate datasets in a manner which makes them more readily understood by more groups is a good thing for statistical research health we do - we highlight the manner in which the BHI presents a lot of data. It deliberately presents data that can be accessible, that's clear, that's transparent, that is disinterested.

Q. That's directed to clinical outcomes?
A. Yes. Some of the data --

Q. Not matters of workforce?
A. No. Some of the data that is captured, from a perspective as a researcher, is quite clunky. It's not easily understood or accessible, and I think going to your point, a collation, to give a broader picture, is a valid pursuit.

Q. But to be clear, you contemplate a body that collates

this material gathered by others; is that right? In other words, you are not contemplating replicating the work that's already done by those various bodies and authorities that we've just discussed?
A. If it data exists there is no point to replicate it through a different body. Where the data doesn't exist on matters such as vacancies, or if it does exist and is not publicly available, that's a different question that I think we've traversed. But there are elements that we think that public policy experts, industrial groups, employer groups, indeed, the NSW Health department, the ministry, would find useful.

Q. You were asked by way of example, I think adopting Broken Hill Hospital as an example, in what way the HSU having insight into vacancies for cleaners, for example, at Broken Hill Hospital would assist the process of recruitment for those positions. Do you recall being asked about that?
A. So our members at a hospital setting are acutely aware of staff vacancies or staff shortages, for example. We believe that the information that they hold, or that data that they hold, effectively, that's what it is, it's data that leads to information, can be useful, can be translated within a particular process.

Q. But that acutely held information - that is, held by your members working at these facilities - I assume the HSU has a process by which it gleans that information from its members from time to time; is that right?
A. We have processes constantly afoot - sometimes it's reflected in direct representation because there might be a short - an issue of staffing at a particular facility, so it might require an industrial officer to go and communicate and negotiate with a hospital management structure; it might be ascertained through the research work that centrally we put to members to ask for their feed back. We constantly do that. We constantly engage in survey work, both survey work, focus group work, research that's both quantitative and qualitative that gives us a picture and that informs the work that we do and the information that we present at forums like this.

Q. So the absence of an independent body of the type you contemplate is not a complete impediment to your union ascertaining the state of affairs at any given health facility, because you can rely upon your existing members

to report back to you - on the ground?
A. I would suggest that it's not the responsibility of our members to report on staff vacancies. We asked them, after hours --

THE COMMISSIONER: That's a bit more of a difficult process, isn't it, to go back to the membership all the time, rather than having the data readily available, isn't it?

MR CHENEY: Well, it might be, Commissioner, but we'll come to that.

THE COMMISSIONER: Anyway, keep going.

MR CHENEY: Q. You do have that capacity to obtain from your members at the coalface, as it were, what the situation is in any given discipline?
A. We have a capacity to invite our members to participate in the research and the survey work that we do, and that gives us a picture. I think, as I referenced in my witness statement, we're not suggesting that we have complete datasets, and again, going back, the work of a clinical psychologist, a physical therapist, a cleaner, someone who is working in food services, might not be to capture this in a manner which is hugely structured, but they can be involved in that process.

We don't think - perhaps more accurately, the point that I'm making is it's not the function of HSU to capture data on these areas. We think that a state-based body has the capacity, the expertise to do that, not a trade union.

Q. I wasn't suggesting for a moment that it was the role of your members or the HSU to procure this data, but can I ask you to assume for the purpose of the exercise that NSW Health holds data relating to vacancies and that data informs recruitment policies. I'm struggling with what it is that you see would be the public benefit of the HSU having insight into that material, in circumstances where NSW Health has that data.

THE COMMISSIONER: Before you answer that, what is your client's position, that there has to be some public benefit for this information to be made publicly available in.

MR CHENEY: Yes, in circumstances, Commissioner, where,

among other things, my client is competing with similar organisations in other states for recruitment data. There may well be aspects of this that are commercially sensitive, and it's not a general - it ought not to be a general --

THE COMMISSIONER: But vacancy rate for particular workers in the health system is commercially sensitive because --

MR CHENEY: For example, if it is perceived that there is an inordinate number of vacancies in a particular LHD or a particular region, that it becomes publicly known, that may well feed in to the expectations of those who might otherwise be interested in fulfilling those roles.

THE COMMISSIONER: There might be pros and cons of any release of information to the public that's about a public health system, but - I mean, I can think, for example, the people involved in local government, particularly in a regional or rural LHD, might want to know what the vacancy rates are for particular workers in the health workforce, because they are the people that get hauled up in supermarkets and in the street and told, "There's not enough X in our hospital", and they have to answer those questions to the citizens, the residents of their local government areas.

There will no doubt be, as I said, pros and cons of releasing public information, but I can't quite see how it's acutely commercially sensitive at the moment, but you will obviously have an opportunity to convince me otherwise at some stage if you want to.

MR CHENEY: Q. Dr Halse, the HSU is not a benevolent arm of NSW Health, is it? It operates with a mandate of improving the conditions of its members?
A. I'm not sure what a benevolent arm - what you're referring to there.

Q. Well, accept the proposition --

THE COMMISSIONER: Q. You are a trade union, right? You represent your workers, your members --
A. Exactly.

Q. -- and you try and get the best deals for employment conditions as you can for them?

A. That's correct.

Q. Is that the fundamental job?
A. Absolutely.

MR CHENEY: Q. You mentioned candidly enough that from time to time it is necessary to resort to industrial action to improve those conditions?
A. That's correct.

Q. And you would acknowledge, would you not, that there would be circumstances in which there would be information known to NSW Health that it may not be in its interests, as opposed to your members' interests, for the HSU to know?
A. That could be an argument put by NSW Health. I don't think it's in the public interest. I don't think it's in the interest of workers.

Q. Sir, in paragraph 18 of your statement, you refer to there being an increasing concentration of health services in metro areas, and you give, I think, an example of Woollahra having twice as many GPs per thousand head of population than does Liverpool.
A. Correct.

Q. You, in a former life, worked in the Victorian system; is that right?
A. I worked in the Victorian government, yes.

Q. It would, I gather, be a common feature of the health system in Victoria that there is a greater supply of medicos in the metro areas than there are in the regions?
A. I think most of the established research across the country, which reflects on the number of medical practitioners or even allied health practitioners, does indicate clearly that areas of higher socioeconomic status have more, proportionally. I think that's a wholly uncontroversial finding across all jurisdictions.

Q. And in your work as a Victorian parliamentarian, you would have had occasion to observe that the fact that the responsibility for general practitioner workforce supply falls to the federal government, can cause some tension with state health systems?

THE COMMISSIONER: I don't understand that question. "Your work as a Victorian parliamentarian, you would have

had occasion to observe that the fact that the responsibility for the GP workforce supply falls to the federal government can cause some tension - can you have another crack at that question

MR CHENEY: Yes, Commissioner.

Q. GP distribution workforce is largely a matter for Commonwealth Government; correct?
A. Through the primary health network.

THE COMMISSIONER: I mean, I have to say, I'm not sure I accept the premise of that question. The witness can answer however he likes, but in the end, I'm the Commissioner.

MR CHENEY: Q. You are aware that NSW Health --

THE COMMISSIONER: I mean, the Commonwealth runs Medicare and it supplies an MBS, which is an insurance scheme, which is tapped into by GPs using certain coding for whatever service they are providing, medical service they are providing, to patients, and it relies on there being a market. It is not a general primary care provider - the Commonwealth is not. It has an insurance scheme that we call Medicare. That's just a fact.

MR CHENEY: I was about to volunteer that it is at least recognised as a responsibility for primary care --

THE COMMISSIONER: Who is, the Commonwealth?

MR CHENEY: -- falling on the Commonwealth.

THE COMMISSIONER: Well, I'm not sure - what do you mean by that? I mean, I don't know whether it is relevant to debate this in front of the witness. Certainly Medicare exists. We know that. But the responsibility for primary care might fall on more than just the Commonwealth.

MR CHENEY: And we've seen evidence that, in fact, it does.

THE COMMISSIONER: Yes, exactly.

MR CHENEY: Q. I'm sorry, Dr Halse, you're aware that NSW Health has invested in significant programs to assist

the relocation of general practitioners or rural generalists to the regions?
A. Yes.

Q. And including scholarships for GP training?
A. Yes.

Q. Or trainees, and the single employer model?
A. Yes.

Q. And the union, I gather, would be supportive of those initiatives?
A. We're supportive of all initiatives that meet the unique distribution requirements to provide health care across New South Wales.

Q. And I think in paragraph 19 you speak about there being a lack of paid placements and a lack of structured programs for allied health professionals to enter?
A. Correct.

Q. You are aware that within NSW Health there are some 23 recognised allied health professions?
A. Yes, I think I reference that.

Q. And each has a different training pathway and different clinical placement requirements?
A. That's right.

Q. And I think that's in part why you have found it difficult, at the start of your evidence, to nominate the number of different areas that are covered by your members?
A. I wouldn't say struggled, I think I referenced that we have such an expansive membership, with unique occupations, obviously there are 23 or so allied health professions that are recognised, or groupings that are recognised, but the point I was stressing is that up and down the health system there is a huge number of distinct groupings. That's the point I was making.

Q. And nationally, all the allied health professional university training courses are accredited by the professions' peak associations?
A. The peak bodies, the accreditation arms will have a role in dictating the accreditation process and a role in coordinating with the university or vocational sector the requirements that are unique to a student's clinical

education.

Q. But the governance over the education curriculum for allied health practitioners rests with the individual universities and the education providers; correct?
A. Predominantly, yes.

Q. By reference to standards set by independent regulatory authorities?
A. Yes.

Q. Such as the Australian Health Practitioner Regulation Agency?
A. Correct, yes.

Q. And the accreditation standards that universities have to adhere to include a minimum number of clinical placement hours that the allied health professionals must complete to be deemed competent to practise?
A. Absolutely, and across the - I think we have a letter tendered through my witness statement that goes into some of the detail, the various hours that are required across a distinct range of allied health professions.

Q. And for many allied health professions, at least a portion of the students' clinical placement time must be spent in large tertiary hospitals?
A. We appreciate that the concentration of existing clinical staff may be in those larger tertiary hospitals, and we understand that there is efficacy in having training set in those areas or those hospitals. We don't contend that.

Q. But that's in part, is it not, because the accreditation requirements demand that, that some of the clinical placement be in tertiary hospital setting?
A. It is in part but I'm not sure it is solely. I think it is in part but not sure it is solely.

Q. I wasn't putting solely, sir. I was suggesting a portion of the clinical placement time must be spent in large tertiary hospitals?
A. That's my understanding. I'm reluctant to delve into every single allied health process and go through all the clinical requirements. I know that there are others who are better placed to comment on those matters.

Q. But in your position, you are aware that many of those positions are hosted by NSW Health?
A. Yes.

Q. And there are other initiatives that, to your knowledge, are in place by NSW Health to support allied health students financially?
A. Financially - I couldn't list off the top of my head all of the initiatives, but it would be of absolutely no surprise that - I'm sure you'd be - to distil through a range of initiatives, and that is a good thing, and it's a common practice among many jurisdictions, state jurisdictions across the country, that they are supporting or they are looking for avenues to support health workers or allied health workers in whatever way.

Q. Including in the form of Aboriginal allied health cadetships?
A. Yes.

Q. And tertiary health study subsidies that are paid by NSW Health?
A. Yes, to the extent - I'm not - I can't confirm the extent of t hat, but if you are putting it to me.

Q. There's also, in addition to those who would be classified as allied health practitioners, there are those who are labelled, for want of a better term, "allied health assistants"; is that a phrase that describes a category of your membership?
A. Yes. Yes, people will classify themselves in that manner.

Q. And they typically work under the supervision of an allied health professional?
A. Yes, they typically would.

Q. And there is currently no formal training pathway for transitioning those assistants to become allied health professionals; is that right?
A. That sounds accurate but I can't say with specificity.

Q. In addition, there's been recent Commonwealth Government initiatives to improve the training position of allied health practitioners in the form of a Commonwealth prac payment; is that right?
A. Yes.

Q. And that supports a selected group of students undertaking mandatory work placements?
A. Yes, teaching, nursing and social work students.

Q. And --
A. And midwives.

Q. And midwives, and that's a payment of about $320 per week while they are training?
A. I think it is pegged to Austudy.

Q. You have made the point I think in paragraph 20 that, as you perceive it, the public health system is reactive not proactive with its identifying its recruitment needs. You would accept that - and I think you have acknowledged as much already - there are significant constraints on the recruitment capacity of NSW Health arising from workforce shortages?
A. It's a challenging area.

Q. You have also observed --

THE COMMISSIONER: That's been well and truly established already in this Inquiry.

MR CHENEY: Q. You have observed in paragraph 22 that there's a lengthy - or at least your members perceive that there is a lengthy recruitment process involved in filling some positions?
A. Yes, as articulated by our members, the feedback that we have received is that - a sense that it takes some time to fill certain positions.

Q. Are you aware that there is a formal policy about it, known as the recruitment and selection of staff to NSW Health service?
A. Yes.

Q. And it's, as you understand it, directed to ensuring that there is at least a fair process for identifying and selecting candidates?
A. We acknowledge that there must be a fair process, that the process must meet the expectations of a particular health service, that the process may - that it must ensure that those who are engaged can engage in safe and proper practice within the context of the service they are

delivering.

Q. And are you aware that NSW Health has set a target of a 40-day time to fill positions?
A. Vaguely aware of that, yes.

Q. You would recognise that as an initiative that's at least directed to addressing the concern that you refer to in paragraph 22?
A. It's a noble intent.

THE COMMISSIONER: I think the length of time for recruitment - a concern about that in a general sense, is not limited to the HSU, I think people within LHDs have shared the frustration, if I can call it that.

MR CHENEY: Yes. Somewhat of a dilemma.

Q. Just finally, Doctor, you refer in paragraph 24 to the health system having a high dependency on temporary staff and you include in your examples of such visiting medical officers. You understand that they are contracted staff --
A. Yes, I do.

Q. -- engaged via a VMO determination?
A. Yes.

Q. And they encompass approximately 50 per cent of the senior medical workforce in New South Wales?
A. We understand it is a huge component, yes.

THE COMMISSIONER: Q. You would accept that whilst in the statement, without being critical, you have used VMOs, locums and agency staff together - you would accept there are separate considerations for VMOs --
A. Yes.

Q. -- as compared to locums and agency staff?
A. Correct.

MR CHENEY: Nothing further, Commissioner.

THE COMMISSIONER: Can I just before I go back to Mr Muston - and this isn't for the witness but just while he's still in the box, prompted by something, a message sent to me and something I said back at transcript page 3755, Mr Cheney, you asked the witness:

... I gather, that there are aspects of outdated awards that impede the efficient ...

Sorry, you asked the witness about what he said in paragraph 27 of his statement, that many health awards are outdated and require organisation, it might be reorganisation that you meant, and the witness agreed with that proposition, and you said:

You've gleaned that perception from your dealings with NSW Health about award amendment?

And the witness said:

That's a common reflection within our organisation.

And I said:

That's the Inquiry's understanding too.

That is, in a general sense, the Inquiry's understanding from things we've been told. But you went on to ask the witness at line 24:

And you would have perceived, I gather, that there are aspects of outdated awards that impede the efficient delivery of health care?

And the witness agreed with that proposition.

I think what would help me, though, in relation to that - and it is not for the witness to give me this help - but it would help if NSW Health could identify for me and this Inquiry what specific awards, or what parts, aspects, of specific awards "impede the efficient delivery of health care", in your client's view, so that we had that, some form of documents with that listed out in table form, or whatever.

MR CHENEY: Yes, Commissioner.

THE COMMISSIONER: So that I've got - no doubt that's your client's view, because you've asked the question, but I'd

like the specifics of it if I could, please

MR CHENEY: Yes, Commissioner.

THE COMMISSIONER: Thank you. Did anything arise out of the questions from Mr Cheney?

MR MUSTON: No.

THE COMMISSIONER: Thank you very much, Dr Halse, we're very grateful for your attendance and you are excused.

<THE WITNESS WITHDREW

MR MUSTON: The next witness I think is Annette Solman. We'll need five minutes just do get her up on the screen, is what I'm told.

THE COMMISSIONER: Do we start or start at 2? I'm happy to start now, I'm just asking you what your preference is?

MR MUSTON: I'm happy to start now, we'll get her up on the screen --

THE COMMISSIONER: I'll just sit here but we'll adjourn until the witness is on the screen.

SHORT ADJOURNMENT

<ANNETTE SOLMAN, SWORN: [12.50pm]

THE COMMISSIONER: Ms Solman, if at any stage you don't hear Mr Muston, who is about to ask some questions, clearly, please let me know and I'll get the question repeated. Thank you. Go ahead.

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Ms Solman, you are the chief executive of the Health Education and Training Institute?
A. Yes, I am.

Q. Referred to in the business as HETI?
A. Yes.

Q. And that's a role that you have held since June 2015?
A. Yes.

Q. You have prepared a statement to assist the Inquiry with its work dated 9 July 2024?
A. I have.

Q. Do you have a copy of that statement handy?
A. I have it in front of me.

Q. Have you had an opportunity to review it before giving your evidence today?
A. Yes, I have.

Q. Are you satisfied that the contents of that statement are, to the best of your knowledge, true and correct?
A. Yes.

MR MUSTON: In due course, Commissioner, that statement will be tendered.

Q. Could I ask you to go to paragraph 7 of that statement.
A. Yes.

Q. Do you see you tell us there that the primary role of HETI is to provide leadership to LHDs, specialty health networks and other NSW Health organisations and training providers on the development and delivery of education and training across the New South Wales public health system?
A. Yes.

Q. Could I just understand, what do you mean when you use the words "provide leadership"? What is the nature of the leadership which is provided by HETI in that domain?
A. Well, HETI is highly skilled in education and training and the development of education and training, and also the development of education and training that's fit for a number of the professions. So we do provide leadership out to the New South Wales health system in relation to our education and training and we engage people from the New South Wales health system who are experts in particular fields to work with us to ensure that the products that we develop in collaboration, advised by experts, are fit for purpose and safe and patient centred. So I do think, you know, when we're talking about leadership, it is that leading with others.

Q. That's a reference I understand to education that's

being delivered by HETI into the system?
A. Yes.

Q. Is there anything else that HETI is doing to provide leadership in the education space to LHDs, specialty health networks and other New South Wales public health organisations?
A. We hold a series of seminars as well around contemporary education and training. So we have speakers, they come in, and that's available to anyone across NSW Health. So we do have certain digital events, virtual events that staff can access.

In addition to that, there is also medical accreditation and that's an area where there are certain requirements to be met for medical education and training, and HETI is also there to support LHDs and specialty health networks in understanding what that means.

Q. We might return to that. Could I ask you to track down to paragraph 9 of your statement where you tell us about some of HETI's main functions. Do you have that?
A. Yes.

Q. I just want to take you down to subparagraph (b).
A. Yes.

Q. Where you tell us that one of HETI's functions is to establish governance for whole of health education and training programs. What does that mean in a practical sense, the establishment of governance for whole of health education?
A. Well, when it's whole of health education and training that we develop, so I'm talking about development now, we have the governance of the development of those modules. There's also health education and training programs that come into the system and we review those education and training programs that are put up by others to ensure that they are fit for purpose and that they are programs that would be suitable to the New South Wales health system.

Q. How does that work in a practical sense? Let's say a regional LHD or a particular hospital has some training that it wants to deliver to a section of its workforce. What does HETI do to establish governance in respect of that particular training?
A. Well, it may not be that this would be something that

HETI would establish governance of. It may be something that's a local issue that can be addressed through local expertise and is then provided within an LHD. If it was --

Q. In that context - sorry to interrupt you, but in that context does HETI have any particular role to play in the delivery of that education output?
A. No, not unless they invited us in. There is a number - there is education and training that occurs in LHDs and specialty health networks that they determine as a local need and that they then address that local need with their education and training staff taking the lead. If they want to or they seek to come to HETI for advice and support, we have very strong relationships across the whole system.

Q. Does that routinely happen, to your knowledge?
A. It has happened on occasion. Sometimes it's not actually in a formal sense. Because we have staff placed all over New South Wales, health, you know, people can engage with others and talk about education and training, so it may not be something that we would be seeking governance of, because it's about responding to a local issue and it's also about not taking away from the LHDs the opportunity for them to respond to their local needs, which may be peculiar to that particular organisation and wouldn't lend itself to a statewide development.

Q. What's the threshold for HETI taking governance of a particular educational output insofar as your view is concerned?
A. Well, within HETI, we have - we design the education and training with the expertise that is available to us and then those programs are offered by HETI, quite often, so the governance stays with HETI. That means that the program is not changed from the evidence-based practice from which it was developed, and we provide that out into the system.

There has been some programs where the staff of the system have implemented at a local level and at a local level they still need to, you know, inform us if they're making any or want to make any significant changes to HETI products.

Q. But if we're dealing with non-HETI original products here, training exercises or training outputs which are

being delivered through the LHDs, for example, is there a particular threshold that you see beyond which they shouldn't be dealt with locally but, rather, they should have HETI governance, and, if so, what is that threshold?
A. Yes, I think there is - anything that could lend itself to a statewide program is something that we are always interested in the LHDs coming forward to see if that has been a request somewhere else. But in relation to governance at a local level, the LHDs can develop education and training that is relevant to meet their specific needs without coming to HETI.

Q. Is there any way that HETI seeks to ascertain whether LHDs are delivering in their own unique way training and education on similar topics across the system, without HETI necessarily having been consulted?
A. There are forums where educational staff come together and certainly a lead from HETI attends those forums, where they may talk about education - well, they talk about education and training. But we don't have a threshold of what an LHD can and can't do in relation to education and training. We encourage them to use the HETI products and not duplicate - that's one thing. But the other is, if there is something they would like developed, there is a process for them to go through and do that, but they still have to be able to respond to local emerging needs themselves.

MR MUSTON: Commissioner, I'm about five minutes off moving on to another topic. Would it be convenient to take those five minutes and then adjourn?

THE COMMISSIONER: Yes, all right.

Ms Solman, we're going to adjourn now for the lunch break so we'll get you back at 2 o'clock.

THE WITNESS: Thank you.

THE COMMISSIONER: We'll adjourn until then.

THE WITNESS: Thank you very much.

MR MUSTON: As the Commissioner pleases.

THE COMMISSIONER: All right. We'll adjourn until 2.

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Yes, Mr Muston.

MR MUSTON: Q. Do you still have your statement available, Ms Solman?
A. I do, thank you.

Q. Could I ask you to go next to paragraph 9 subparagraph (c) and at the top, of at least what on mine is page 3, do you see the Roman numeral (iv) there, which commences "Statewide oversight coordination"? Do you see that paragraph?
A. Yes.

Q. Could you just explain to us in the context of reforming and improving workforce capacity and the quality of clinical and non-clinical training, what you mean in that subparagraph there?
A. So HETI has had a role in simulation for quite some time and has developed simulation standards because there are - simulation occurs in many areas of NSW Health. So there is best practice learning standards for creating simulated learning environments as a teaching and debriefing mechanism.

Q. That's the simulated learning. I see immediately before that you have used the word "including", so is there anything else you were referring to in that paragraph other than simulated learning environments?
A. Well, we do have oversight, working - looking at any new - to make sure the policy - make sure the education and training is up to date with policy.

Q. How do you do that?
A. Well, we do get notified of policy changes through the Ministry of Health functions and we do regularly review the content. Quite often, if there are going to be some changes, particularly from ACI or the Ministry of Health they have actually spoken to us if we already have training in place and have included us in those conversations.

Q. So that's - to the extent, if I've understood you correctly - that HETI is delivering courses itself --
A. Yes.

Q. -- the oversight that you are referring to there is

ensuring that the courses being delivered by HETI are kept up to date with any changes or developments which come from the ACI or elsewhere?
A. Or any policy owner where we have a program of learning that's associated with the policy, yes.

Q. What about education and training which is not being delivered by HETI but is being delivered by other organisations within NSW Health? Does HETI have any statewide oversight, coordination or implementation of best practice in respect of that?
A. Through the RTO, if it's a registered training organisation level course, courses will come up through that process, if that is a qualification, it will come up through HETI's processes. Generally the LHD, specialty health networks and Ministry of Health, they alert us well in advance of something like that happening and they do include us in those conversations.

Q. In what way through those conversations does HETI exercise statewide oversight coordination and implementation of best practice?
A. Of those particular programs - through direct involvement, if that's required, but also ensuring that they do meet the standards for an RTO course which has its own set of standards.

Q. So just to make sure we're not at cross-purposes, are the RTO courses being delivered by HETI or by other organisations?
A. They could be both, by other organisation or by HETI.

Q. In what sort of context would another organisation within health be delivering an RTO course?
A. If they identify a specific need in their LHD that's peculiar to them, they may develop an RTO course, it may be a succession planning or building capacity of a particular workforce in that area. They may do that through an RTO mechanism.

Q. What sort of course would be delivered for the purpose of succession planning and delivering workforce in a particular area?
A. Well, succession planning is thinking about, well, what is the workforce now and into the future. So through the RTO there are a number of courses that, you know, look toward ensuring that people have the capabilities, so it

could be in a management course; it could be in a leadership course that has particular needs. So if it is going through the RTO processes, it means that it meets the criterion for a qualification.

Q. So HETI is an RTO; is that right?
A. Yes.

Q. Which other entities within health are formally recognised as RTOs, to your knowledge?
A. None to my knowledge.

Q. None, did you say? Sorry, I missed that.
A. None, to my knowledge, are RTOs.

Q. So when we're talking about RTO courses, we're essentially still dealing with those courses which are being delivered by HETI, aren't we?
A. No. LHDs may be able to deliver the courses, if they have the necessary qualification and experience. So, yes, they can deliver courses locally.

Q. That would be delivering a course, though, that was a course provided through HETI as an RTO, wouldn't it?
A. Well, it could be, unless it was an RTO that was privately engaged. But I'm not really seeing that these days.

Q. Have you in the past had an experience of organisations within NSW Health engaging other RTOs, that is to say, other than HETI, to deliver courses to their workforce?
A. Well, I've seen - I've seen organisations go outside of health to have an RTO course written for their needs.

Q. But in terms of the delivery of that course, for it to be recognised as an accreditation, it would need to have been delivered by an RTO, would it not?
A. Yes.

THE COMMISSIONER: Q. I think some of the confusion might be coming from where you said that the LHDs are able to deliver the courses if they have the necessary qualifications. What did you mean by that?
A. Well, there are qualifications required to deliver different levels of courses, and I'm just thinking back, when you asked me the question about the RTO, there were

a couple of LHDs who can deliver RTO courses because they are registered.

Q. That's something that they do outside of HETI?
A. Outside of HETI, yes.

MR MUSTON: Q. Can we move down to subparagraph (d) in paragraph 9, where you identify one of the roles and functions of HETI being to institute, coordinate, oversee and evaluate education and training networks. Can I ask, what are those training networks that you're referring to in that paragraph?
A. They're the medical training networks.

Q. So when you say "medical training", what type of medical training are we talking about there when you are alluding to those networks?
A. Junior officer medical training.

Q. Prevocational PGY1, PGY2?
A. Yes.

Q. We might come back to that. Is it that same medical training that you are alluding to when you refer in the next paragraph down, subparagraph (e), to setting standards for education and training, and training including medical training?
A. Yes, and that sits within the medical portfolio of HETI.

Q. So what is the standard-setting role that HETI has?
A. That is to ensure that the standards are met by the institution to ensure safe practice and support for pre-vocational education and the person is getting adequate supervision.

Q. So I understand conceptually that making sure standards are met is an important consideration in training, but what does HETI do to set - by way of the setting of standards?
A. Yes, so there are prevocational standards that need to be --

Q. And just pausing there, what's the source of those standards? Are they something that HETI comes up with or are they externally derived?
A. I believe they're externally derived but I think that

Dr Jo Burnand from medicine will be best placed to answer that question.

Q. Just to the extent that you have alluded to in your statement in relation to HETI having a role in setting standards for education and training, I'm just trying to understand what that role is.

THE COMMISSIONER: It may be the drafting of the statement is not quite right.

MR MUSTON: Maybe.

Q. Do you have that at subparagraph (e)?
A. Yes.

THE COMMISSIONER: Q. When it says "to set standards", do you mean that HETI is setting the standards, where you've got that in (e), or is it HETI ensuring that other standards are maintained or met?
A. That other standards are maintained and met.

THE COMMISSIONER: I think it is just a drafting issue - maybe.

MR MUSTON: Q. Moving down to paragraph (f), HETI's role to maintain registration as a higher education provider - is that its RTO role that we're talking about or is that a different role?
A. No, that's a higher education role. It's a tertiary accreditation level, and that was - HETI was required to undertake that assessment and institute that process because it was transitioning the former institute of psychiatry into HETI, so that was something that we had to develop up the resources, policies, et cetera, to actually be accredited as a higher education provider.

Q. So is that because HETI took over the delivery of certain courses which had previously been delivered by another organisation?
A. Yes, that organisation was - ceased to exist and before that happened it needed to come to HETI. So that was a very new thing for HETI, it was something that we hadn't undertaken before, and we're very pleased that we were able to achieve that accreditation.

Q. So having achieved it, you'd been delivering the

course that had been - the courses that had been delivered by the predecessor organisation?
A. Yes.

Q. Have you developed any new courses?
A. Yes, applied mental health course, which is non-medical staff - medical staff could do it as well, but it's mainly for health professionals.

Q. Could the witness be shown on the screen exhibit A.048 from the November hearings, which is document [SCI.0001.0043.0001]. Ms Solman, can you see that document on your screen?
A. It's a bit small. So the workforce plan?

Q. Yes. Are you able to see that? Do you recognise that as the NSW Health Workforce Plan 2022-2032?
A. Yes.

Q. Could I ask that we go forward to page 7. That's 0007. Do you see there there's a reference to three horizons, being the phases of the plan as I read it. You would be familiar with the concept of the three horizons in the workforce plan?
A. Yes.

Q. If we can turn over now to page 8, do you see the three horizons are described in a little bit more detail there, the first horizon being the 1 to 3 year period, where it's proposed to develop and embed?
A. I can't read the writing.

MR MUSTON: Perhaps we could zoom in on, if possible, the one --

THE COMMISSIONER: The witness is having to read it on the screen.

Q. You are looking at it on the screen, are you?
A. Yes.

THE COMMISSIONER: We'll try to make it as big as possible.

MR MUSTON: Q. Is that any better, you see "Horizon 1, Years 1-3, Develop and Embed"?
A. Yes.

Q. You are familiar with that period, which I think we must be just approaching the end of - that is, the first horizon, the first three years of the plan?
A. Yes.

Q. Is that your understanding of it, we've got 2022, 2023, 2024?
A. Yes. Sorry, I'm just --

THE COMMISSIONER: Is there any significance to the symbol above horizon 1? I wonder what that cost. Anyway.

MR MUSTON: Keep your eyes peeled.

THE COMMISSIONER: Yes, something like that.

MR MUSTON: Q. Perhaps if we go over to page 10. Do you recognise that --
A. I do recognise the document, yes.

Q. -- page as setting out the various priorities which are sought to be advanced through the workforce plan?
A. Yes, yes, I do.

Q. And then if we go to page 11, do you see a slightly more detailed --
A. Yes.

Q. -- description of how those various objectives and the particular outcomes which are identified are sought to be achieved?
A. Yes.

MR MUSTON: Can we perhaps zoom in, operator, as best as we can on 1.1 at the top of the table, just so Ms Solman can see it. It might be a little bit too much. Let's pause there for a minute.

Q. Do you see there 1.1, "Strong leadership embedded across the system to sustain a progressive, inclusive, safe, healthy workplace"?
A. Yes.

Q. Then the first of the bullet points:

Train senior employees in leadership,

mentoring and coaching to support on the job learning.

A. Yes.

Q. If we then move across a little bit to the right, you see that's an outcome which was to be achieved by 2024 - that is, by now?
A. Mmm-hmm.

Q. If I've understood this document correctly, the lead, or the organisation within health who's responsible for achieving that outcome, is HETI?
A. Yes.

Q. In respect of that one, what has HETI done?
A. Well, we have got programs of learning around mentoring and in leadership. We've also been developing up the just in time resources, and the wellbeing leadership program to ensure leaders have the skills to support resilience in the workplace - that is something that we have been working on but wellbeing is also woven into other leadership programs.

Q. So when you talk about programs, are these online courses that people can do or what are they?
A. Well, they're more interactive than an online course.

Q. In what way?
A. So online learning can be just looking - looking at a screen and going through and doing something on your own, whereas, you know, the wellbeing - looking at leadership programs, coaching and mentoring, they are more active types of programs where people are involved in doing things.

THE COMMISSIONER: Q. Does that mean there is, for example, with coaching, an actual coach, a human being?
A. People may have coaches out into the system, but it's - if I go to training employees in leadership, there has been a number of leadership programs across the state offered and delivered. Mentoring is also offered and delivered and coaching to support on the job learning, that is something that pretty much most people would think was important.

Q. Everyone does on the job learning, or most people do,

but the leadership courses - are these - when you say they are interactive, are they online and interactive some way, or are they with the support and involvement of human beings that are doing the leadership training?
A. So the leadership courses have been more likely to be face-to-face over a period of time, and the mentoring as well, a component of that. Coaching is something that can be online certainly. With the current environment, we are not really going out into the system to deliver programs; we are running them centrally, or from another area, where people dial in. So they are still face-to-face. The content is still there. The learning objectives are still there. So the opportunities to engage with people are still there, it's just a different way of doing business.

Q. What did you mean by "current environment"?
A. Well, to go out into LHDs and travel, I mean, that has a travel cost, it has accommodation costs quite often, and it has a time cost.

Q. Yes.
A. One of the things that HETI has - I'm very proud that HETI has done really well is it has developed up its capability in designing and delivering programs across the state that are best practice level using the virtual medium. For that to work obviously we need to partner with the organisation we're working with to do that, whereas before there would have been a team of people who travelled, who probably had to stay a night or two to do that. So it's more efficient, we do have the expertise to do this, it ' convenient for learners, they don't miss out on content, they're not missing out at all, and it also reduces potentially travel time for participants if they were going to be coming in to do a program.

So I do think the way that we have recreated the way we're doing our business also gives us time back that would be travel time to actually focus on, you know, doing more work in the system.

MR MUSTON: Q. Perhaps we could jump forward to page 14 of that document. Do you see there 4.1,

> *Ongoing opportunities to learn and upskill so our workforce are fit for purpose for now and the future.*

A. Mmm-hmm.

Q. Do you see there there are three - if we move across just a tiny bit to the right, you see there are three particular activities which HETI got lead responsibility for. Working through them, the first, measuring and assessing workforce capability. That's something that apparently is happening this year. What's HETI doing in relation to its measurement and assessment of workforce capability against the New South Wales Public Service capability framework?
A. Well, it's about ensuring that someone who has undertaken a particular program, that we're mapping the public service capability framework to our existing programs so that people either in the public service or in - health is part of the public service, obviously - that they will have the same capabilities.

Q. What does that actually mean, though, in terms of what HETI's in the process of doing? Is it collecting a list of courses and accreditations taken by people who are within the health system and making that centrally available to the public service, or is it about changing the nature of the courses that are being delivered so that they align with particular public service objectives? What is HETI actually doing?
A. Mapping against the public service capability framework.

Q. What does that mean in terms of someone sitting at a desk and doing something?
A. It means that they're looking at the public service capability framework and they're looking at the content and the objectives of a HETI program and mapping that to see where, if, in fact, there are gaps.

Q. What about the next point up, "Uplift workforce capability through a standardised approach to organisational learning" - that's something that was to be achieved last year. What did HETI do on that front?
A. Well, we had to set a standardised approach to organisational learning. So we do have statewide resources that are standardised across the state so that people are learning the same thing no matter where they work. So that's one of the things that we're doing. There has been a mapping exercise as well. I don't have that information on me --

Q. Mapping of what?
A. Well, looking at what are the standardised approaches to organisational learning. So ensuring that the program is fit for purpose, that the objectives of the program are being met and that the workforce can translate the program into practice, because you can read something, but superficially it makes no change. This is a --

Q. Can I just ask, are these comments that you are making in respect of programs and courses that are being delivered by HETI?
A. Yes.

Q. Is any attempt being made to uplift workforce capability through a standardised approach to organisational learning insofar as that learning might be occurring outside of HETI through either the LHDs or any other aspect of the wider public health system, or that's not part of your understanding of that activity?
A. That's not how I have read that activity.

Q. What about the last point in that box:

Establish a Community of Practice to create, design and build a culture of organisational learning.

That should have been done, according to this, last year. What did HETI do on that front? Let me ask this question in two ways. First of all, what do you understand that last bullet point to mean?
A. Well, it's about having people come together to create a community of practice and to look at how to encourage and support cultures of learning.

Q. So in what sense are these cultures of learning being encouraged or is it seeking to encourage cultures of learning?
A. Yes, so there's, for example, collaboratives that occur, so there is the allied health team that comes together at different times and --

Q. That's a community of practice, I gather?
A. Yes, more along the lines of community of practice, or it could be professional development.

THE COMMISSIONER: Q. What should I understand "Community of Practice" means? Is there any significance in the fact that "community" has a capital C and "practice" has a capital P? Is it some document or --
A. Well,"community of practice" is a term that is used and that is generally people coming together to co-design, who have the expertise - I'm only talking about education now - and to encourage health professionals, in this instance, to continue their professional development. So, you know, organisational learning, "build a culture of organisational learning", for me, is about how do you encourage and support people to continue their professional development ongoing, because that's what is required of health professionals to do.

MR MUSTON: Q. So what has HETI done to encourage that as part of this process?

THE COMMISSIONER: Well, it's - "establish" is what's meant to happen. I don't know.

MR MUSTON: Q. What has HETI established?
A. I'd have to come back to you on that one, if I may. I don't have that --

Q. So as you sit there, you are not aware of any particular work that HETI has done to establish communities of practice to create, design and build a culture of organisational learning?
A. No, sorry.

Q. Moving down to 4.5, the very last point there:

We focus on social determinants of health and preventative care.

and the last point is:

Work with tertiary and VET sector education providers to incorporate a focus on the social determinants of health and preventative care at tertiary institutions.

Do you see that?
A. Yes, I can see that.

Q. And do you see that according to what follows, it

seems HETI was to take the lead on achieving that by the end of last year.
A. I can't comment if we did that or not. I'd have to come back to you.

Q. Do you know whether HETI's done any work with tertiary or VET sector education providers to incorporate a focus on the social determinants of health and preventative care at tertiary institutions?
A. I don't know.

Q. Okay. Move down to 5.1. Do you see the last bullet point there:

Upskill key workforce segments to create base-level capability to interpret, use and report data to inform decisions?

A. Mmm-hmm.

Q. Do you see again that's HETI project for 2024? What's HETI done on that thus far?
A. I really can't comment on that, I'd have to go back --

Q. That's not something you have been involved in?
A. I haven't been directly involved in it, no.

THE COMMISSIONER: Q. What do you mean to convey by saying you haven't been directly involved in it? Does that mean you know something about it?
A. It means that I don't recall this piece of work.

THE COMMISSIONER: All right.

MR MUSTON: Q. So can I just try and make sure our understanding of HETI's role within the public health system is right. First, you have a role as a training organisation delivering a range of courses to employees of NSW Health.
A. Yes.

Q. And they are online or virtually delivered courses?
A. And some have been face-to-face.

Q. And some have been face-to-face. How many courses, in total, does HETI deliver?
A. Oh, there is a lot of courses.

THE COMMISSIONER: Q. You don't have to give a specific answer to that, it can be ballpark.

MR MUSTON: Q. Ballpark is fine. Is it 10? Is it 100? Is it 1,000?
A. Well, if you are looking at courses, there's a lot of courses that are developed in the digital medium, and there are courses, then, that are offered in the virtual medium, and then there's some a sprinkling of courses that have been offered in the face-to-face medium. So it would be quite substantial, the number of courses that have been developed by HETI.

Q. So just to make sure we're not at cross-purposes, there are courses that have been developed and there are courses that have been delivered?
A. Yes.

Q. When you refer to a substantial number of courses, these are courses which, on any given day, HETI is delivering - have we understood that correctly?
A. We may not be delivering the same course every day, but - because it doesn't work like that, but we would be delivering them over a period of time.

Q. So the next thing I think you tell us that HETI has a role in, at paragraph 47 and following of your statement, is the management of scholarships and grants.
A. Yes.

Q. What are the grants that you refer to being given for?
A. The grants generally are from the Ministry of Health, and --

Q. Yes, for what?
A. They could be for travel, they could be for - to attend something, and scholarships are also offered, and they can be to undertake a program of learning. So there's a whole range of things that fit under that category.

Q. Who decides who gets a grant for travel, say?
A. Well --

Q. Is it HETI?
A. Well, if HETI was administering something for travel - travel is probably a bad example, to be quite honest. So

the grants - whoever is eligible to apply for the grants can apply for the grants, is how I would frame it. The grants may be used for different reasons. It might be to further or upskill your clinical capabilities, something along those lines; or it could be to have a qualification, a further qualification. So that's what generally those grants are about. They are about opportunities for staff development.

Q. So members of the workforce apply for those grants. Who decides whether or not the applicants get the grant?
A. It depends on who is managing the scholarship. So if I go to nursing and midwifery as an example, they have a working group who look over and make recommendations. And then if I look at allied health, they've got something similar. So they're two examples I can put out there about --

Q. So when you say there are working groups, are they working groups within HETI or are they working groups within the wider health system?
A. Well, they are actually conducted by the nursing and midwifery office.

Q. So in relation to, say, a nursing grant or scholarship, applicants make an application for a scholarship, it's assessed by the working group, a decision is made by the working group about whether or not to give someone the scholarship or the grant. What's HETI's role?
A. HETI's role is to administer the scholarships once they have been decided. We don't - and we are not the sponsors of the scholarships. We are not the owners of the money.

Q. So when you say "administer the scholarships", do you mean make sure the money gets paid?
A. Yes, that's what I mean. And there's quite a number of scholarships that are offered by NSW Health for different reasons.

Q. Is there a particular skill set or capability that HETI has which means it's well placed to be administering the scholarships in the sense that you've just described?
A. Well, HETI has been administering scholarships for many years, so HETI does have the expertise to do that.

Q. But the expertise - the only expertise - that is required to administer the scholarship is to pay the money, as I understood your answer, but maybe I misunderstood you.
A. Well, that's part of the process, but it's also data entering everything for others to make a decision.

Q. But that's - sorry, I may have misunderstood it.
A. Processing.

Q. That's a decision around granting the scholarship?
A. It's about receiving the applications for scholarship, ensuring that they meet the criteria in broad terms, and then we - then someone else will then look at those, a group of people generally. If I think about the nursing and midwifery office, they make the decision about who - through a group, they will make a decision about what scholarships will be awarded to these people.

Q. But I think we've perhaps already traversed this, but that group is not a group within HETI, I think you told us; that's a group outside of HETI that's making that decision?
A. It's - it is a working - it is an advisory group who makes that decision. So there is representation from HETI but there's representation from a whole lot of other people as well.

Q. Can we jump forward to paragraph 50 of your statement, where you tell us about the role that HETI plays in the clinical placement of students. Do you see paragraph 50, you tell us that HETI's role is as the central body that administers student placements in consultation with the Ministry of Health. Do you see that?
A. I'm just coming - what number was that?

Q. Fifty, 5-0.

THE COMMISSIONER: Page 12, I think.

MR MUSTON: Q. Do you see that paragraph?
A. Which paragraph was it, sorry?

THE COMMISSIONER: Q. Paragraph 50. It commences "HETI's role is as the central body"?
A. Yes.

MR MUSTON: Q. I just want to ask if you could then go down to paragraph 54 where you tell us the student

placements are undertaken and governed at a local level between the public health organisation and educational institution, and that HETI does not have any role in this process.
A. Yes.

Q. Do you see that? It's not entirely clear what HETI's role - what HETI is doing in its role as a central body administering student placements having regard to what you tell us at paragraph 54?
A. At paragraph 54 there - well, basically what we do is - so there's a number of players who are involved here in a student placement. So we collect - we don't really do a lot of what is here.

Q. Sorry, I misheard that. Did you say "we don't really do a lot of what is here", in paragraphs 51, 52 and 53?
A. Well, we do. The ClinConnect system is what we use for clinical placements, and universities and TAFEs will put in their requests. The LHDs determine how many placements they have, and then HETI has that information and uses that information for student placement.

Q. But the universities and educational institutions often have their own stand-alone agreement with LHDs, don't they, that govern issues like student placements?
A. They may have arrangements. I couldn't talk to that. They usually - yes. There's usually feeder universities, geographic feeder universities that, from my experience, local health districts have that would - naturally you want to, if you've been studying in a local area, you would be looking at potentially having your clinical placement in that area, if that's the area that you want to work in, because the university would have that relationship with the LHD.

Q. And the university and the LHD in that context make arrangements for a number of placements that they can offer and the areas in which those placements are able to be offered; is that right?
A. We don't have anything to do with that. That would be the LHDs determining placements, I would suggest.

Q. Which brings me back to my original question: when you say in paragraph 50 that HETI's role is as the central body that administers student placements in consultation with the Ministry of Health, what does that --

A. We have a central --

Q. -- central role as an administrator actually involve?
A. It involves in making the system available to the providers and it also --

THE COMMISSIONER: Q. Sorry, "making the system available"? What's the system?
A. Well, sorry, the ClinConnect system, which is to book and manage placements in New South Wales, and part of that is ensuring that certain documents are submitted, but really, the work of the ClinConnect will be determined by the LHD and the provider. So it's really - HETI hasn't got a big role here apart from administering the ClinConnect system.

MR MUSTON: Q. So next topic you tell us about at paragraph 56 is medical intern recruitment.
A. Yes.

Q. These are the graduates of medicine who are commencing their PGY1 year; is that right?
A. Yes, yes.

Q. And when you say HETI manages the applications and allocation of medical graduates applying for their internship positions, what does HETI actually do on that front?
A. I've gone blank, I'm sorry. (Reads document). So the applications would come to HETI and then the allocation of the graduates - yes, I would have to look at the detail on that one --

Q. So you are not immediately familiar with HETI's role in relation to the management of application and allocation of medical graduates applying for internship positions; is that right?
A. We do have a process, that's --

Q. No, my question is you're not, as you sit there now, able to call to mind what that process is?
A. No. Let me just think about this.

Q. Can I take you to paragraph 62 of your statement. You see you tell us there that:

HETI would welcome greater consultation

with LHDs planning training and development to identify where it is duplicative or where it could be developed and shared statewide.

What's the current nature of the consultation that occurs between LHDs and HETI other than the occasional meeting of education providers that you told us about earlier?
A. Oh, HETI has a lot to do with the local health districts, and specialty health networks, particularly in product development. We utilise the experts in the system so they - very close relationship overall.

Some of the LHDs let us know about what they're doing in relation to perhaps creating or updating a hospital and they may have increased - thinking they may have increased training needs, so that then impacts on how many junior doctors might be available, et cetera, and also any training that might be required in any other area. So it's just - some of the work that we do has been duplicated elsewhere, but there's less of that occurring now, and some that we don't know about, and it's been very good quality work, would have benefited many people by being a statewide product over a local product.

MR MUSTON: I have no further questions for this witness, Commissioner.

THE COMMISSIONER: Thank you. Mr Cheney?

MR CHENEY: Nothing, Commissioner.

THE COMMISSIONER: There's no further questions for you, Ms Solman, so thank you very much for your attendance. We're very grateful for your time.

THE WITNESS: Thank you.

THE COMMISSIONER: You are excused.

THE WITNESS: Thank you.

<THE WITNESS WITHDREW

MR MUSTON: The next witness is Dr Josephine Burnand.

<JOSEPHINE BURNAND, affirmed: [2.47pm]

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Dr Burnand, you are the acting medical director of HETI at the moment?
A. I am.

Q. Only just?
A. Only just. Three weeks ago.

Q. And when you are not acting in that role, you are the deputy medical director of HETI?
A. Correct.

Q. Which I think is a role you have held since 1 November 2021?
A. That's correct.

Q. You have prepared a statement dated 11 July 2024 to assist the Inquiry with its work?
A. I have.

Q. Do you have a copy of that statement with you?
A. I do.

Q. Have you had an opportunity to review it before giving your evidence today?
A. I have.

Q. Are you satisfied that the contents of it are true and correct to the best of your knowledge?
A. It is.

MR MUSTON: That will be tendered in due course, Commissioner.

THE COMMISSIONER: Yes.

MR MUSTON: Q. You tell us in paragraph 3 of that statement that you are responsible for the medical portfolio within HETI?
A. Correct.

Q. Is that essentially a focus on, as I think you tell us in paragraph 3, the training of or delivering education to doctors within the system?

A. It's the medical portfolio oversights the delivery of training for prevocational trainees across the state.

Q. So I think there are three things you identify in paragraph 3. The first is overseeing the allocation of final year medical students to intern positions?
A. That's correct.

Q. The second is providing support for early career doctors during the prevocational period?
A. Correct.

Q. I'll come back to that, but that's training that they're receiving during PGY1, PGY2?
A. Correct.

Q. And then the third is managing a number of prevocational and vocational training networks in New South Wales?
A. That's right.

Q. I might touch on each of them separately. Starting with the allocation to intern positions, which you tell us about in paragraph 10 and following. The first very small question in paragraph 10, you tell us there that HETI has a delegated authority from the ministry to allocate graduates to intern positions, but the employer of each intern is the relevant LHD.
A. (Witness nods).

Q. Just in respect of that last concept, is it not right that the employer of each intern is the secretary?
A. Well, the LHD actually are - my understanding is the LHD are the actual employers of interns.

Q. Perhaps we need not get caught up on the technicalities of who the official employer is, is the concept that you're seeking to convey there that there is a budgetary allocation within each LHD for a particular number of interns, and the interns, having identified that - sorry, the LHD, having identified that budgetary allocation, then tell you, "We would like to take on, in our LHD, X number of interns"?
A. Correct. The LHD determine the number of intern positions.

Q. Could I ask you to jump forward to paragraph 13. The

starting point is, as you have just told us, the LHDs and St Vincent's determine the number of interns. So is my understanding correct in saying that if they say, southern LHD might say, "We need 150" - "We've got capacity for 150 interns", another LHD might give you a different number, and you then collate all of those numbers centrally?
A. We seek - at the commencement of the process of allocation of intern positions, we seek approval from each LHD, signed off by the chief executive of the number of positions that they have capacity for.

Q. So having done that, you then --

THE COMMISSIONER: Q. Can I just ask, when you say "have capacity for", does that mean the need to meet the demand for the provision of the health services that the interns are providing, or does it mean the budgetary capacity? Or is it some combination?
A. It's probably some combination of that. So each LHD determines the number of intern positions that they wish to have.

Q. Wish to have because of the need to provide the medical services they do or because of the budget they either have or are going to have?
A. Interns have a role in providing direct clinical care for patients under the supervision of more senior doctors.

Q. Yes.
A. They are not the only junior doctor in the team, though. So PGY1 or intern positions are at the sort of most junior of the team.

MR MUSTON: Q. Another consideration is the capacity to actually provide training opportunities for these PGY1 interns, presumably?
A. Correct.

Q. It's not the case that you could, say, send a PGY1 intern out to man an otherwise unmanned or "unpersoned" emergency department in a remote area, for example?

THE COMMISSIONER: "Undoctored".

MR MUSTON: Q. A doctor-less emergency department?
A. Well, they are doctors, they are provisionally registered and by the way of being provisionally

registered, they are required to be appropriately supervised by more senior doctors.

Q. So if you have a remote, or even not that remote, emergency department that doesn't have sufficient number of senior doctors on site, you can't use your intern workforce to fill those sorts of gaps?
A. Correct.

Q. So having identified the number of interns which the various LHDs and St Vincent's are willing to take and the way in which those intern positions are distributed, how does - what is HETI's involvement in determining how many interns to take and where to send them? Perhaps if you could talk us through it from a perspective of someone who has just grasped their degree and they are about to become a PGY1 intern. What do they do?
A. So HETI provides the overall coordination for New South Wales for intern applicants, and, you know, there are a number of other New South Wales entities that contribute to that work, but essentially, HETI, having sought the number of available intern positions, there is a portal which is a module of ROB, which is our recruitment and on-boarding system run through HealthShare. An intern would go on to the site, or a final year medical graduate, sorry, correct me - a final year medical graduate would go on to the website and there is an application process under one of those four pathways that I mentioned at paragraph 11.

Q. So just dealing with those four pathways, the Aboriginal medical workforce pathway alluded to in subparagraph (a) is for medical students who identify as being First Nations people?
A. Correct.

Q. The rural preferential recruitment pathway is for medical students who have expressed a preference to work in a rural area?
A. We have a number of sites through New South Wales that allow direct merit-based selection, if you like, ahead of our optimised allocation pathway. So hospitals such as Orange, Wagga, Tweed Heads, Lismore - there's a number of them - are part of our rural preferential pathway. They are also part of our networks, but that pathway is specifically for final-year medical students who have a wish to work in a rural location.

Q. And are they students who might have been - might have completed the clinical component of their university training through one of the clinical schools out in a regional rural area, for example in Orange or Wagga?
A. Typically but not always.

Q. So if, hypothetically, a metro-based medical student decided that they really wanted to go and work in Tweed Heads, they would apply through the rural preferential recruitment pathway?
A. They are eligible to apply, correct.

Q. And you referred to a merit-based appointment. What is it about that process? What are the merits that are being assessed in the context of a fresh graduate?
A. Each of the rural preferential - like, the participating hospitals in the rural preferential recruitment pathway basically run a recruitment process that is not dissimilar to other employment processes. So they would apply through that pathway, they are then usually, typically, interviewed and a merit list of the - from the hospital's perspective of the preferred applicants is constructed and from there they are offered according to the number of vacancies.

Q. Is that offer made by HETI or made by the --
A. No, that offer is made by the recruiting hospital, LHD.

Q. So having entered the system through the HETI portal, the hospital then gets connected with these students who have expressed a desire to be there and, assuming that they match up, HETI's at least immediate role in the placement of those students --
A. This is quite complex. A final-year medical student wanting to apply for the rural preferential pathway would actually put an application in for that pathway, to whichever hospital - so that might be multiple hospitals - as well as generally also through the optimised allocation pathway, which is where they would default if they were not successful in obtaining a rural preferential pathway position.

Q. So they go through the interview process at each of the hospitals that they have applied to. If they get offered an intern position there, they essentially fall out

of the scheme and take up that position. If they are not offered an intern position at one of those hospitals or don't take one up, then they just default to the normal pathway taken by all other candidates?
A. That's more or less correct. I mean, HETI continue to oversight until - and obviously HealthShare, we have an actual portal that is run through eHealth called MIRA, which is the medical intern recruitment allocation, that's a module of ROB, so all of the interns are through that portal, but essentially what you have described is correct.

Q. We'll come back to the optimised allocation pathway in a moment, but the next one you allude to is the direct regional allocation pathway. What is that?
A. That's the third pathway, which is intended to allow for hospitals who might not be part of the rural preferential pathway, but there are a number of hospitals that traditionally and historically have been less population, if you like, in terms of preferences that final year medical students would give when they're nominating which network, prevocational training network, they would like to go to, and so there are a number of facilities that are part of that pathway.

In terms of the way that that is - so - and you would have seen in my submission, there's a priority list, which is set by NSW Health, which describes the priority order in which interns, or final year medical students, are allocated.

Any category 1 to 4 student is eligible to be appointed directly through that regional pathway. So they have nominated one of those facilities, such as Gosford Wyong, and they are category 1, they will be appointed to that ahead of the algorithm being used for the optimised pathway.

Q. So for the candidates who don't find their way into an intern position through one of those first three pathways, they're in the mix as part of the optimised allocation pathway?
A. Correct.

Q. You mentioned a moment ago that there is an algorithm. How does that pathway go about identifying which students go where?
A. Each student will preference, as part of their

application process, which of the prevocational training networks they would like to go to, so there are 15 prevocational accreditation networks, and each network comprises a number of facilities within it. So they will preference that and there is an algorithm which is run through the MIRA eHealth portal which basically allocates, and the idea is that the algorithm is designed to provide the most number of final year medical students with their higher preferences.

Q. So it's not based on the results you got at university, for example, or --
A. No.

Q. -- necessarily where you live or where you studied, it; rather, each candidate who wants to get an intern position will allocate preference 1 down to four, five, whatever it is?
A. Fifteen, yes.

Q. And then the system will - the algorithm will run through and work out what combination of allocations can be made to ensure that as many students as possible get as close to their top preference, if not their top preference, as can be accommodated across the system?
A. Correct.

Q. And having been offered one of those positions, unless you want to go interstate to take up an offer that might have been made by some other state public health system for a training position, you take what you get?
A. Correct. You accept the offer that you are provided.

Q. You mentioned a moment ago the networks, the 15 training networks. How do those networks operate? I think you touch on it in paragraph 28 of your statement, if that helps - the prevocational training networks. Again, perhaps explain it from the perspective of a trainee or an intern who has applied for their preferences and maybe been given preference number 2, which sees them starting at - pick a hospital that would be a good example, RPA is an easy example for me to come up with, but might not be a good one. Tell me if it's not. So the student starts at RPA. What does the network mean in terms of how their training progresses over the next two years?
A. So the first thing to say is that they're actually allocated to a network. So they're not specifically

allocated to Royal Prince Alfred Hospital, they're allocated to the network. The networks are numbered 1 to 15, not in order of popularity. So when they are allocated to that network that has Prince Alfred Hospital, it also has a number of other hospitals within that network, so, for example, for Prince Alfred, it has Canterbury Hospital and also Dubbo. So it has a regional facility as well.

Q. Pausing there, do all of the networks have that spread across metro and regional/rural hospitals?
A. Generally, yes. Most will. I mean, there are, for example, some - Hunter New England is a good example where they have both John Hunter Hospital and a number of networks across Hunter New England LHD. Many of the other networks across the prevocational training networks actually also cross LHD boundaries, so they may not be all within a specific LHD.

Q. So just in relation to that, when we started in our discussion earlier and you were talking about the LHDs identifying the number of positions that they have, do they need to tell you that by reference to the actual hospitals that those positions are available in?
A. Correct, yes.

Q. So for the purpose of the network, you know, for example - the example you have just given - that you might have X number of interns that can be accommodated at Dubbo, four-X at RPA, two-X at Canterbury, and so that gives you a total number, which is the pool of available intern positions in network number whatever it might be?
A. That's correct.

Q. So as part of that allocation of students into the networks, the allocation allocates only the number of students as can be accommodated by that - by the summing of each of those various parts of the network?
A. That's right. That's exactly right.

Q. In terms of the training itself and which hospital particular candidates go to and in what order, how does all of that work?
A. Within the network?

Q. Within the network?
A. Is that the question? So that generally, I mean, each intern, if we're talking about interns, but also

prevocational trainees in their second postgraduate year, so an intern is allocated - well, a final year medical student is allocated, they're on a two-year contract, and they will complete in their first year five terms of approximately 10 weeks duration, and the same again in their second postgraduate year.

So those terms will be in any of the participating facilities within that network and generally that's worked out in, if I use the North Shore example, probably, that would be worked out by their central JMO unit so, the term allocations for the year, including any terms that they're doing outside of North Shore hospital in that example.

Q. So the networks are administered at a more local level?
A. Correct.

Q. Once HETI has done the allocation of candidates into each of these various networks, the precise way in which those candidates might roll through RPA, Dubbo, Canterbury is determined by --
A. That's right.

Q. -- those hospitals?
A. (Witness nods).

Q. With a view to ensuring, presumably, that each of the candidates gets their full exposure to everything that they are required to be exposed to as part of their PGY1 year?
A. That's right. Yes.

Q. In terms of the rural component that might be part of a network, say the RPA/Canterbury/Dubbo, it's a relatively short period of time potentially that a candidate might be spending as an intern in Dubbo under that arrangement?
A. An individual JMO, that's correct. They may be there for 10 or 11 weeks.

Q. Is there any consideration given as parts of the JMO training to the potential desirability of exposing JMOs to longer - even those who might not have expressed a preference, to longer periods of training within rural and regional areas?
A. Not all - well, the first thing to say is not all prevocational trainees will necessarily complete a rotation in a rural facility. Has there been any consideration

given to longer - well, certainly through our - for those that desire to work regionally, in fact, the system was changed many years ago to, through the development of the regional - the rural preferential pathway, to accommodate those prevocational trainees who, in fact, wanted to remain in a regional location.

Q. To some extent, the system is preaching to the choir in terms of exposing them to the desirability of working in a regional area - that is to say, those who have expressed a preference to do so, the system might not need to work too hard to persuade them that their decision has been a good one. I'm more interested in those candidates who have not expressed that preference. Has the system given any consideration, so far as you are aware, to the desirability of compelling JMOs to spend a longer period than, say, 10 weeks in a regional or rural area to potentially expose them to the benefits of working in such an area longer term?
A. When you say "the system", has the --

Q. HETI and the prevocational medical training arrangements?
A. I could speak more broadly, that it's certainly across the medical education continuum, it's certainly been a topic of conversation, if you like, in educational fora around the desirability. There are a number of challenges to compelling, you know, prevocational trainees to move to regional locations, as in compelling them, and certainly the feedback we get from trainees is that, you know, for some, they're really interested in having a short-term, and even if they're not necessarily wanting to go there in the first instance, they come back from those terms and have had really good training experiences.

But it goes to - I mean, again, it's complex. There are a number of - I think there are a number of challenges in requiring people in their, you know, first, second year, to go for long periods of time. Most can accommodate 10 weeks.

Q. So in terms of requiring, for someone who is - just to stick with our earlier example - RPA/Canterbury/Dubbo --
A. Mmm-hmm.

Q. -- if the dice fall out in a way which means they get a 10-week stint in Dubbo, they don't have an ability, do

they, to say, "I'm not going to Dubbo, I'm going to stay at RPA"?
A. No, they are generally - I mean, they are an employee and part of the deal, if you like, is that there may be a chance and an expectation that you will be allocated. But rather than seeing that as a negative thing, you know, obviously, experiences people get in regional and rural hospitals are incredibly valuable training, and they're different experiences to what they might get in a big metro tertiary facility.

Q. So doctors get to the end of their PGY1 and they get general registration as a consequence of that?
A. That's right, if they have met the requirements for Medical Board of Australia's general registration requirements, then they will be recommended by the sort of administrative hospital, if you like - there is a process - if they have met the requirements they will be recommended to be moved from provisional registration to general registration with the Medical Board.

Q. And after that point, do they have to go on to do PGY2, a further year of five rotations, or are they able to go out and work, say, as a locum?
A. They don't have to, in a - I mean, they obviously have a two-year contract. In New South Wales, they are provided with a two-year contract. They can obviously resign from that contract and seek work elsewhere.

Q. In your role with HETI, do you see that as something which is happening often - that is to say, students who have received their general registration at the end of their PGY1 year are not continuing to the end of their PGY2 year because alternative opportunities are available to them?
A. In my current role I don't have any direct visibility of the attrition, if you like, of PGY2s. We certainly anecdotally hear of PGY2s leaving their posts some time during the PGY2 year.

Q. Is it possible for someone to leave their post during the PGY2 year to take up a vocational training position or is that not something that is typically an option for them?
A. It is an option for them. So some colleges will have entry into vocational training in the PGY2 year. Sometimes, in the case if I can use the College of General Practitioners, they can be accepted on to the college

training program but they remain in their prevocational accredited post doing their hospital year in their second year. The College of Pathology has historically, as has the College of Psychiatry, accepted PGY2s on to their program. In the case of the College of Psychiatry, they have recently made a change that from the 2025 clinical year, they won't be accepting PGY2s into their training program, but they would need to, in fact, under the national framework, which I have also mentioned in my statement, have a certain of completion. It would be expected that they would have a certificate of completion of the PGY2 year.

Q. I was going to ask you next about the national framework. In a practical sense through, the eyes of our hypothetical intern, what will be the change brought about by the national framework?
A. There are a number of changes with the national framework, and probably from the eyes of the intern, it is intended to provide a two-year period of consolidation of skills across a broad range of - you know, give them opportunity across a broad range of clinical disciplines. It is intended to strengthen supervision and feedback through the introduction, which will come hopefully next year of entrustable professional activities, supported by a national ePortfolio, and finally there is a very strong emphasis on cultural safety through the national framework.

Q. Would the national framework mean it is necessary for interns to complete their PGY2 year without breaking their contracts?
A. Importantly, the national framework is not a two-year internship. So the timing of move from provisional to general registration still occurs at the end of the first 12 months. But it is intended to give an additional year to consolidate those skills under the supervision prior to entry, for those cohort of doctors that are going into vocational training.

Q. Does the introduction effort national framework operate, or will it, do you think, to disincentivise in any way the exodus, to the extent there is one, during that PGY2 year into other roles such as locum roles?
A. That's probably difficult for me to answer. It wasn't the intended - the intent of the national framework. It may be a second-order impact. Colleges - with the College of Psychiatry being a good example - have now suggested

that they would expect an Australian graduate to have a certificate of completion as a pre-entry requirement. Obviously the more colleges that recognise the value of that two-year period of consolidation of skills prior to entering vocational training, we might expect there would be more incentives to complete, because it would, you know, obviously ensure that you've got what you're going to need to enter vocational training going forward. That's really difficult to say.

Q. I'll come to vocational training in a moment. In paragraph 36 of your statement you tell us that HETI does not have a direct role in the private health system in New South Wales but as a prevocational accreditation authority it accredits prevocational training sites which include some private hospitals and general practices. What is the role played by private hospitals in general practices in the prevocational training of medical graduates in New South Wales?
A. So we have a number of private hospitals that have rotations available for interns and PGY2s.

Q. Are they part of the networks or do they sit outside the networks?
A. In some cases they're part of networks, in other cases they actually recruit directly through a Commonwealth scheme to intern positions, but after the pathways that I've - well, towards the end of those pathways I've just spoken to you about.

Q. So I assume we're not talking about St Vincent's, as a privately owned albeit part of the public health system; we're talking about other private hospitals --
A. Correct.

Q. -- out there in the health system?
A. Yes, yes.

Q. Are interns able to get their full suite of five rotations solely within a private hospital setting or is it just part of a rotation that they need to do which will necessarily involve the public system?
A. In some cases they are able to get, but they also - the private hospitals where they are not an emergency medicine have historically been, until the introduction of the national framework, a place where they might be rotated to the local public hospital to complete that.

Q. Just so we can get some sense of the scale of the private hospitals we're talking about, in New South Wales, what would be an example of a private hospital where interns are retained and able to obtain their training?
A. So if I use the example of Macquarie hospital, private hospital, Macquarie University private hospital, although they do have some rotate, so although they directly recruit some interns, they are also part of a broader network and they are part of a secondment arrangement with other hospitals.

Q. I probably should have raised this earlier but in terms of that allocation of graduates to intern positions, our understanding of it is that students who have completed a degree in New South Wales, which is a fully Commonwealth funded degree are, guaranteed an intern position in New South Wales somewhere?
A. So if they've completed in a New South Wales based university, correct.

Q. Sorry, I have jumped that step. Attended a New South Wales university on a Commonwealth funded position, graduated with a degree in medicine, they're guaranteed an intern position in the New South Wales public health system somewhere?
A. If they are - according to the priority list which was provided in my submission, which is the NSW Health policy, if they are an Australian citizen or permanent resident.

Q. Candidates from interstate institutions, who have completed a degree in medicine, either a Commonwealth funded position or a non-Commonwealth funded position, can make application but have no guarantee of an intern position within New South Wales hospitals?
A. So - sorry, could you just repeat the first part of that question?

Q. A candidate who has qualified at an interstate university, so someone who might have attended the University of Queensland, for example, obtained a medicine degree --
A. Yes.

Q. -- they're either Commonwealth funded or --
A. Full fee paying.

Q. -- it might not be possible, full fee paying, I don't know whether the University of Queensland does that, but either way, they could apply for a position within New South Wales but they have no guarantee of getting a position?
A. Correct. They have a guarantee of getting, in the Queensland case, a position in Queensland.

Q. Maybe just teasing out the fully funded Commonwealth position as opposed to the self-funded position, a candidate who has obtained a degree from a university in New South Wales, having paid for that degree themselves, they can apply --
A. It can be a full fee paying or a CSP, so a Commonwealth funded position.

Q. So a full fee paying student, do they have a guarantee of an intern position in New South Wales?
A. As a category 1, that's my understanding.

Q. And at the other end of the spectrum, there are internationally trained medical graduates who can make an application for an intern position within New South Wales. No doubt there are complexities which arise depending on which jurisdiction they've obtained their training, but assuming that those complexities are overcome, they have a right to apply but no guarantee to an intern position in New South Wales?
A. That's right.

Q. From your perspective at HETI, how do things sit at the moment in terms of supply and demand for intern positions in New South Wales hospitals?
A. So I can't give you the exact numbers, but we started this clinical year off the intern allocation of last year with quite a large number of vacancies in New South Wales, that we understand from our interstate colleagues has been replicated across the country. So in other words, at the moment, we exhausted all of the categories according to - in terms of allocation for last year, and we still had vacancies at the end of that process.

Q. So if we take a few steps forward into the vocational training space, our hypothetical intern has completed their PGY1, hopefully we've managed to keep them in PGY2, they then have a desire to become a specialist and practise in some area. Pausing there, they don't have to become

a specialist if they don't want to?
A. No.

Q. They can become a career medical officer, working in the hospital system?
A. They can become - they can continue to work in the hospital system as an unstreamed doctor, so not everybody enters vocational specialist training in their PGY3 year.

Q. So those who do have a desire to pursue specialist training, putting to one side the general practitioners which have a slightly different pathway, for those within hospital based specialisations, they get to the end of their prevocational training, how do they go about pursuing vocational training? What's the process?
A. Are you asking with respect to the HETI prevocational training networks or broadly across the system?

Q. Let's start in general. I appreciate different colleges might have different requirements, but at a very general level, if I was sitting there as a recently finished PGY3 person, what would my process be in terms of deciding whether I wanted to become a specialist and, having decided I did, pursuing that objective?
A. So you would apply to both - in general terms, you would apply to both the college, the relevant specialty college, as an applicant - and colleges have different stages at which they will accept entry, they have different prerequisite requirements - and, in addition to that or sometimes it's a parallel process, again, depending on the specialty, you also would apply for a job that was a vocational accredited position within, in this instance - I mean, I've spoken very broadly across the country, but in New South Wales you would apply through our annual medical recruitment for a training position.

Q. So, just to unpack that a little bit, there seem to be two, if not three, elements. The first is there needs to be a registrar position funded out of a site somewhere within the particular area of specialisation that you wish to pursue?
A. Yes. I mean, this is not a HETI responsibility, so I'm relying on my broader information in answering these questions.

Q. So second, the site needs to have been accredited by the relevant college --

A. Correct.

Q. -- for that training position. And the third is, the college needs to have accepted you as a trainee or vocational trainee?
A. If you're going to be accessing an accredited training position, that's generally the way it works, correct.

Q. So in terms of decision-making, putting to one side the site accreditation, which is obviously a matter that's outside of our control of our hypothetical JMO, are there - who makes decisions about whether or not to accept the JMO into the college, on the one hand, and whether to accept them into the registrar's position, on the other? If it's different people, what happens then, if they make different decisions?
A. They are different people, they are different decisions, and they are made in different ways. So in some colleges, they - particularly in the advanced training component - they might accept a trainee and then allocate them to specific jobs. Now, they are still subject, obviously, to all of the usual pre-employment checks that one would expect, and processes in on-boarding them.

In other examples, the trainee would apply, again, through the annual medical recruitment, to a position. They may get accepted to a position and then they apply to the college following that. So it is different and has different timings for --

Q. So in some cases, the college has accredited a range of positions which are funded by the LHDs, those registrar salaries, notionally funded in the LHDs at sites accredited by the college, and the college accepts a candidate and then delivers that candidate up to one of those positions?
A. That might be one mechanism.

Q. And in an alternative that you're aware of, an LHD or particular department within a particular hospital employs someone in their registrar position and that then triggers, in a practical sense, the acceptance of that person onto the training program --
A. Provided they have met the prerequisites, and sometimes, in the case of psychiatry, those processes happen at the same time, so the same interview for selection - or employment is used for selection into training, so there is the appropriate representation of

LHDs and the college.

Q. So coming to HETI's role, you have told us about some vocational training networks that HETI is involved in the administering of. Outside of those networks does HETI have any role to play in relation to the vocational training of specialists?
A. No.

Q. In terms of the vocational training networks, you describe them in paragraph 38, but perhaps in a practical sense and through the eyes of our hypothetical JMO now registrar, how do they work?
A. The training networks are all quite different and - I mean, I've mentioned in my statement the basic physician training, which was the initial network training to be established in New South Wales, as probably the most mature, if I can use that terminology.

But in addition to that, we have psychiatry, paediatrics - basic training in paediatrics, medical administration, advanced training in general medicine, and emergency medicine and radiology, so those - they all operate a little bit differently.

Q. So each of the colleges which hover above those training plans have, through the delegation that they have, set upon a particular set of standards or a course of study that an individual needs to satisfy in order to become a specialist in their given field?
A. So the colleges are responsible for setting the standards and the requirements for fellowship; correct.

Q. And so in the context of some areas of specialisation there is a need to, much like your intern year but albeit on a larger scale, rotate through a range of different areas, say paediatrics, for example, might be a necessary component of a training schedule?
A. Yes, correct.

Q. How does that operate in the context of the networks, the vocational training networks, that HETI is involved in? Perhaps to cut to the chase, I'll tell what you I understand to be the case and you can tell me if I'm wrong. The networks and the positions associated with the training networks contemplate a registrar effectively being guaranteed a job which will take them through each of those

various elements of the training that they are required to complete in order to become a fellow of the college.
A. Yes. They - each trainee will have different requirements and different rotations, so the networks provide the mechanism by which it's an integrated training program, if you like. Not all of your vocational training is necessarily done, if I use your example before, at Royal Prince Alfred. In fact, there's great value in having experience in outer metropolitan hospitals, in regional facilities. So networks bring together those groups of facilities and, you know, coordinate the rotations, if you like.

Q. So a candidate who has been accepted to a network position at, say, Royal Prince Alfred Hospital, to use that example, a general physician or basic physician training, will rotate through whatever departments they need to rotate through as part of that training and then they might be sent to the Children's Hospital at Westmead for a rotation potentially?
A. Not for basic physician training. For paediatric, they would be at one of the two - three children's hospitals anyway. But they might be sent to Dubbo, for example, but for a longer period of time. Their terms tend to be three to six months.

Q. And part of that, the benefit of the network, is that the student or the registrar who has been accepted into the network position will know that, throughout the course of their vocational training, everything that they need to have delivered to them in order to satisfy that training will be delivered to them in a position that they have been employed in around a range of facilities?
A. That's correct. The networks are set up so as to meet the college accreditation requirements and enable and facilitate, if you like, individual trainees meeting their requirements for gaining the sorts of clinical experiences that they need to get for fellowship requirements, but at the same time, obviously, they are also providing direct clinical care of patients in those facilities.

Q. And so as they move from one of those clinical requirements to the next, which may be in a different facility, they don't need to go and apply for another job in that facility and hope that they are employed in that next little requirement; it seamlessly happens for them?
A. For the majority of those networks that I have

described.

Q. What's HETI's role in the administration of those networks?
A. We - well, HETI - oversight, so the broad governance structure, and again it's a bit different for each of the networks. So what we've just described is correct for basic physician training and paediatric training, but not for medical administration training. So they're very much individual sites rather than a training network, and trainees will apply at each stage, at each year, for a position. So that's a bit different.

But generally, HETI's role is in oversight and the governance of those training networks to ensure that trainees have the, you know, opportunity to rotate and also, I mean, our focus at HETI is obviously on the education that has been delivered to them, that there are opportunities to ensure that trainees, no matter where they are in New South Wales, have access to the same education and training opportunities. So there's a coordinating function, if you like.

Q. Colleges whose vocational training is not one of HETI's networks do nevertheless sometimes have a range of different requirements that need to be satisfied in order to achieve fellowship?
A. Correct.

Q. For example, I think I recall reading in the evidence that the anaesthetists are required to complete, amongst other things, a paediatric rotation and a cardiac rotation, I think?
A. I'm not across the specifics of the current ANZCA requirements for training. I can't answer that question.

Q. My question in relation to it, without needing to descend into the precision of it, are there networked arrangements that sit outside of those administered by HETI whereby registrars who have been accepted onto a training program, say, by the anaesthetists, have that same opportunity to seamlessly rotate through each of the different rotations that they need to rotate through in order to obtain fellowship?
A. I am aware that there are - I mean, in some of the other specialty training networks rotations are organised in that way.

Q. Do you know how those rotations are organised outside of the work done by HETI?
A. No.

Q. We've seen several times a reference to what seems to be described as an unaccredited registrar. As we understand that term - and again, tell me if you've a different understanding of the term - it seems to be a registrar or junior medical officer employed in a position in a department that doesn't actually have an accredited training position available?
A. Available?

Q. Or they are not on a training pathway?
A. They are not on a formal training pathway.

Q. What's the difference between a formal training pathway and a not formal training pathway in terms of the career progress of the hypothetical registrar?
A. So again, broadly speaking, "unaccredited registrars" is a term that's used for junior doctors in their PGY3-plus year generally, who are often working as part of a broader team which may have accredited registrars, but that's not always the case, sometimes they might be working in a facility where there isn't an accredited vocational trainee working in the same team.

Again I'm going to speak broadly rather than specifically. Unaccredited registrars positions are often occupied by people who have a desire to get on to a training scheme - so surgery is a good example of that - and they are providing within those clinical departments important clinical service, you know, direct care of patients.

Q. But in so doing they are not achieving anything in terms of their progress towards fellowship other than potentially bringing themselves closer to a point where they might be successfully able to obtain entry into a training pathway?
A. That would, in general terms, be a reasonable statement to make. They are gaining, though, important clinical experience. They are still under the supervision of more senior doctors in their provision of care, so they are actually gaining experience, which will undoubtedly assist them in their future career endeavours.

Q. But in terms of collecting each of the tokens of experience that one has to collect in order to get to the end of the road and say, "I now wish to be a fellow", this unaccredited registrar position doesn't actually give you any of those tokens; it just gives you learned experience which no doubt will make you a better doctor in the long term?
A. In general terms, it doesn't - that's correct. It's correct to say that that experience or time is not counted towards your accreditation, in general terms.

Q. In paragraph 50, you tell us about the funding of some of the HETI vocational training networks and the various ways in which that operates. Can I just ask this question: where a network exists, are LHDs funded by the ministry to employ registrars who are being trained in the network, insofar as you are aware? Is it the ministry who delivers that funding for that training position to the LHD?
A. In general terms, that's correct, it would be as part of their budget. Not always. There are some registrar positions that are provided through - particularly in regional places - Commonwealth funding under the specialist training program.

Q. In relation to --

THE COMMISSIONER: Sorry to interrupt, can I just check, no doubt this has been done, but Professor Twigg, has he been given a message?

MR MUSTON: He is going to be very quick, and I won't be very long.

THE COMMISSIONER: Is he? Right. Okay.

MR MUSTON: Q. In terms of decisions about where those trainees are employed and where the networked trainees are deployed, who makes those decisions?
A. Sorry, could you repeat the question, please?

Q. Registrars are brought into a network. Registrars who have a networked training position are obviously able to be employed out in the system at various parts of the network as it sort of is formed and no doubt is a dynamic thing. But how are decisions made about which hospitals, for example, and which LHDs, networked vocational trainees go

to?
A. Is that question in relation to the vocational training networks that HETI has --

Q. Yes. Yes.
A. Yes. So in some cases - I mean, it's always the decision of the local health district or facility that they want to create an additional position, and then there is a process that occurs in terms of - and obviously they need to, if they're going to have an accredited trainee, seek accreditation of that site through the college, and in addition to that, the state training council - they use the physician basic training, state training council - would have a look at the positions in that network and approve the addition, if you like, of those positions.

Q. Could I ask you to go to paragraph 70 of your statement. Just briefly, could you develop what you tell us in that last sentence, your belief that one of the key challenges relates to the limited time available to senior doctors to provide both direct patient care and training? What is the real issue and the cause of the issue that you identify there?
A. Well, I think what we have seen - and, you know, I have some direct visibility of this in previous roles, less in my current role - is increasing demand on our clinical services. I think that's well documented across the system. Senior doctors make a really significant contribution, you know, they're training and supervising across the whole training trajectory from medical students right through.

The colleges have a number - for vocational trainees, have a number of requirements and assessments that need to be completed, likewise, the national framework going forward will - they currently are required to complete mid-term and end-of-term assessments for our prevocational trainees. But just on a day-to-day interaction with trainees in a busy clinical environment, what we're hearing back at HETI through our senior doctors on all of our committees is that there is less and less time to have those conversations with trainees, because of the clinical demands. Now, there's got to be always a balance, of course.

THE COMMISSIONER: Q. Can I just ask a question about that, and it may sound like a very naive question, but I'm

a lawyer, not a clinician, so I'm going ask it. Where you say the key challenge is the impact of increasing community demand on clinical services and the conflict between the time available for senior doctors to provide direct patient care - now, I understand that, senior doctor providing direct patient care - and then the time available for the same doctors to supervise and train junior doctors, I imagine there are at least times where the senior doctor is both providing direct patient care but is also supervising and training junior doctors, because they are there as part of that process, maybe, but there's obviously a separate time requirement for training that you're talking about with senior doctors. Can you just explain that to me?
A. Yes, it's actually --

Q. Where they're doing something that supervises or trains a junior doctor but it doesn't involve them providing direct patient care?
A. So those same junior doctors - if we put medical students aside, but the same junior doctors are providing the clinical care of the patients, generally, under which those senior doctors are ultimately responsible. So in many ways they are supervising whilst caring for the same cohort of patients.

The time aside is to, in probably - and this is not a HETI specific thing and I'm speaking a little bit anecdotally here but just to sort of give by way of example. A surgeon providing - take the example of an emergency physician providing care in an emergency department, doing a procedure, may do that themselves or they may supervise a trainee doctor undertaking that procedure, which is obviously a slower - not obviously, but in many cases, that might take longer than if they were doing it themselves, if I can explain.

Q. So an example I can give of tripping outside a hotel and needing some stitches inside my nose, when I went to the hospital, a junior doctor saw me, looked inside my nose and sort of went, "Gee, I'm not touching that", and came back with what I think was the registrar or a more senior doctor, who said, "Yeah, you can touch it, provided I'm standing here and watching you stitch up". That's part of the training?
A. Correct.

Q. But there are other aspects where the senior doctor

isn't actually involved with the patient but is still providing training to junior doctors; is that by way of conversations or what are we talking about?
A. Yes, by way of conversations, by assessment processes, providing feedback. You know, they may have collected - a director of training, if you like, may have collected information about an individual trainee from their senior colleagues and providing them feedback, explaining particular aspects of, you know, if I use your example of an injury --

Q. It's important we get my entire medical history onto the transcript for this Inquiry. Go on.

MR MUSTON: There can't be much left.

THE COMMISSIONER: I will get to my psoriasis in a minute.

Q. Yes.
A. I think the point I'm trying to make here is that that can sometimes take longer to have those reflective discussions, but they are really critical to that individual junior doctor's professional development and learning in terms of actually learning how to treat patients.

THE COMMISSIONER: Yes, thank you.

MR MUSTON: I have no further questions for this witness, Commissioner.

THE COMMISSIONER: Nothing arose out of that?

MR MUSTON: No.

THE COMMISSIONER: Mr Cheney, do you have any questions?

MR CHENEY: No, Commissioner.

THE COMMISSIONER: There are no further questions for you doctor, thank you very much. We are very grateful for your time. You are excused.

<THE WITNESS WITHDREW

THE COMMISSIONER: So Professor Twigg is here?

MR GLOVER: Yes.

<STEPHEN MAURICE TWIGG, sworn: [3.48pm]

<EXAMINATION BY MR GLOVER:

MR GLOVER: Q. Professor, if you just state your full name for the record, please?
A. Professor Stephen Maurice Twigg.

Q. You are the head of department of endocrinology at RPA?
A. That's correct.

Q. And also the head of the central clinical school, which is part of the Sydney medical school of the University of Sydney?
A. Yes.

Q. And to assist the Commissioner in its work, you made a statement dated 11 July of this year; correct?
A. That's correct.

Q. That's [MOH.0011.0014.0001]. There is a screen to your right there but you might have a hard copy with you. Feel free to use whichever you prefer.
A. Thank you.

Q. Have you had a chance to read it again before giving your evidence today?
A. I have, thank you.

Q. Is it true and correct to the best of your knowledge and belief?
A. It is.

Q. If we can start at paragraph 3, and there you tell us about the experience that I've just taken you through. Just briefly, can you just describe the role of the central clinical school and how it fits in with the broader Sydney medical school?
A. Certainly. So the central clinical school, if you like, is the frontline for the delivery of the medical education, the curriculum, the learnings for medical students within that clinical school at the University of Sydney, and there's at lease seven clinical schools that feed into Sydney medical school, which, if you like, is the

next level up in the University of Sydney in medicine.

Sydney medical school is responsible for the development of the curriculum, the syllabus, the learning objectives and the assessment processes. Central clinical school is responsible for the delivery of the educational program, within both the university and particularly at Royal Prince Alfred Hospital, in the setting of central clinical school across the four years of the medical degree.

Q. Is part of that process the placement of medical students in clinical placements at RPA, for example?
A. That's correct.

Q. And you have an involvement in that processes, do you?
A. I certainly do, from the point of view of directly and to some degree indirectly organising the placements of the students across all the different specialty areas in RPA, there are tutorials, lectures, ward-based programs and placements as well, and in addition to that, then, the teachers, the educationalists, the academics, the affiliates who undertake the education. So the organisation of the educational program from the point of view of the physical environment where the students learn, but also realising then the educators to enable the students to learn particularly in a hospital setting at RPAH.

Q. We'll come back to some of those features in a moment, but just in terms of the process about how a medical student comes to be placed in a clinical placement at RPA, could you just tell the Commissioner in general terms how that operates?
A. Initially the medical students are recognised as medical students at the University of Sydney into admissions by making an application, and depending upon their success with the process of application, then they will be formally accepted into their medical degree, which is a postgraduate degree at the University of Sydney. Then, subsequent to that, the students identify their preferred clinical school in which they would undertake the placement and the Sydney medical school helps determine the distribution of the students across the different clinical schools.

Q. And in terms of whether a student ends up in a

placement at RPA or elsewhere, is that a decision made by the university or is the hospital involved as well?
A. The university typically will make those decisions and - but communicate with the hospital as to medical students who have been allocated initially for year 1. And then usually, if a student commences in year 1 at a clinical school, they will progress into years 2, 3 and 4, recognising that some students will end up in, if you like, placements, rural and regional placements, and there are some electives during that time.

Q. We'll come back to rural and regional placements in just a moment. In paragraph 7 of your statement you describe in general terms the nature of the education delivered to students in a clinical placement and you described some of those earlier. I just want to touch on some of them briefly with you for those of us in this room, all of us, most of us, who are lawyers, not doctors,
A. Yes.

Q. In terms of the education delivered in the hospital setting, you describe lectures, classroom tutorials, tutorials on the ward, simulations and hands-on experiences in paragraph 7. Could you just in general terms take us through what that might look like on a practical level?
A. Thank you. So one key example would be the tutoring of students where they are allocated in a small group, often three, four or five students, to a tutor. There would often be a process in which, with the tutor, the students will attend the wards in the hospital. They will be able to see patients in terms of making medical assessments and determine provisional diagnoses and then a management plan.

So under a closely supervised format, those students will learn different aspects of medicine. Say it was a respiratory, a lung problem presenting with shortness of breath, they will see a series of patients who have been admitted with those problems and then take an appropriate medical history, undertake an examination, in a structured way, and then work through the assessment management plan. So that would be a tutorial with a tutor.

Q. Who fills the role of the tutor? Is that a clinician employed by the LHD?
A. Usually it is, and practically always, but it can be a salaried academic through the University of Sydney or it

can be a salaried academic through the Sydney LHD, and sometimes we have admixtures. For example, I'm a clinical academic, I'm employed by both. So that is, for example, the tutoring process.

In other settings, students have ward-based placements in which they will link in with the junior medical staff and they will then undertake the ward rounds with the more junior staff, the consultations and learn, if you like, from that perspective with a ward designation.

They are two key examples, ward-based placements and tutoring, that will occur to enable the students to understand how the health care delivery occurs in an inpatient setting and also to be able to interact with the people with medical conditions.

In an ambulatory care setting as well, students often end up in placements, so, for example, I'm an endocrinologist, diabetes is our most common condition and we have medical student placements within our diabetes centre and they will sit in with the doctors, the nurse educators and learn in that way.

Q. When you say "sit in with the doctors and the nurse educators", these are staff of the relevant facility in which the placements are being undertaken?
A. That's correct, and with consent of the patients and approval of the staff, they will accompany the staff member in the assessment process of the patient in an ambulatory setting.

Q. And are there any arrangements between the university and the facility to ensure that those students are being exposed to a broad range of experiences in those placements?
A. Yes. Each placement, there is a careful working through by particularly the University of Sydney and central clinical school. We have education support officers and managers. We have processes to ensure that our tutors are teaching the curriculum, quite a clearly prescribed curriculum in each - every day is carefully designed across the entire medical degree. It is a very tight time frame for the students to learn all the materials.

Q. You touched on this earlier, but in paragraph 9 you

tell us that in some cases, students might train for limited periods in rural and regional areas.
A. Yes.

Q. How might the student come to undertake a placement in a rural and regional area?
A. Some clinical schools are positioned at those sites, but from the point of view of central clinical school, the students can make a submission that in their third or fourth year of their training they would request an entire year of placement in one of the clinical schools, and that happens with a minority but a significant minority of students.

Others request that during their elective periods, which are typically approximately eight-week periods in year 3 or 4, that they have a medical placement in a rural or regional setting. And then we also have general practice and community blocks as well, where students can request their general practice placements would occur not in a hospital setting but in a primary care setting in a rural and regional site.

Q. So in each of the examples that you have just described, these are initiated by students themselves making the request to undertake placements in rural and regional settings; correct?
A. Yes, except that opportunities are provided to the students who can then indicate if they are keen, willing to take up the opportunity, and it doesn't always match, but very often, opportunities who are interested and prioritise the placement will be successful in the placement.

Q. Do you see benefit in students being encouraged to train rurally and regionally as part of their careers?
A. Certainly and we strongly encourage students to do so in our central clinical school and in Sydney medical school, and not all students take up the opportunity, but I would say a majority do over the course of their degree.

Q. What do you see as being the benefit to students at this stage of their training undertaking placements in rural and regional areas?
A. Rural and regional health care is a challenging area related to the geography in New South Wales, and we know that to provide specialist care in those sites is difficult, and also primary care. It can be a highly

rewarding experience where students and more junior doctors, in some ways, can have a greater ability in clinical management to get more involved and immerse themselves in the experience. By the same token, some students find that sometimes they can be isolated, though, in that situation, and some respond better than others.

Students who originate from a rural and regional setting - and that's approximately 20 per cent of the students at the University of Sydney - are much more likely to commence then as medical doctors in a rural and regional setting, but we have seen some students, from having the immersive experience, then willing to and keen to take on the rural and regional placement.

You might have noticed my CV, I undertake care and have for more than 10 years in the Far West of New South Wales, an Aboriginal healthcare facility, and I'm very familiar with the demands and the needs of health care, particularly outside urban settings, particularly in the environments where I've been lending support.

Q. So do I take it from that answer that you have directly observed a correlation between students, as early as this stage of their career, undertaking training in rural and regional areas to then going on to practise as practitioners in those areas?
A. Yes.

Q. In paragraph 5 of your statement you describe your functions as head of department at RPA?
A. Yes.

Q. And towards the end of the third line, you tell us that one of the functions of the department is advanced trainee supervision for those undertaking endocrinology training. Do you see that?
A. Yes.

Q. These are trainees on a specialist program with the Royal Australian College of Physicians, are they?
A. That's correct.

Q. Can you just describe in general terms, what are the supervision requirements of those trainees within your department?
A. So there is an accredited training program for each of

the training positions from the Royal Australasian College of Physicians through the specialist advisory committee and so there is a weekly timetable which describes the inpatient/outpatient activity; the number of patients that are seen, new patients and follow-up patients; the supervisory arrangements of those doctors in training; and also the consultations spectrum that is undertaken.

So the accreditation program occurs each five years through the College of Physicians. In the nuts and bolts on a day-to-day basis, there are two allocated supervisors in the department of endocrinology. I'm one of them for two of our trainees and then we have a co-supervisor.

We meet formally with these students at least four times a year, but in reality much more often than that, formally and informally, and we - every clinic that occurs for our advanced trainees in endocrinology has a supervised consultant who is on site, will supervise the advanced trainee in terms of their assessment and management of the patient and provide advice on a regular basis.

So we have, in total, fractions of 20 endocrinologists in our department and the vast majority of them contribute in the clinic supervision of the advanced trainees, and then we have the two formal supervisors for each advanced trainee through the College of Physicians. We provide a biannual report, formal report, to the Royal Australasian College of Physicians regarding the progress of each trainee during their training and their allocations to us are on nearly a calendar year training; the training starts often in February and completes the next February.

Q. Can I just ask you a couple of things about that answer. You said, I think, you meet formally four times a year but more frequently informally; did I understand you correctly?
A. Yes, yes, that's correct. I mean, we - I will leave it at that. We even have more often other formal meetings, but the college has a requirement of at least four dates indicated for meetings, and we easily meet that quota.

Q. And you said also that there are fractions of 20 endocrinologists in the department who contribute to the supervision of those trainees; is that right?
A. From clinic to clinic, in terms of the reporting and undertaking responsibility for the advanced trainee

progress, there are two allocated supervisors. That's correct.

Q. But everybody in the department assists in the training of those trainees?
A. Practically everyone. Practically everyone.

Q. Are they all staff specialists within your department or are there VMOs as well?
A. No. We have two VMOs, these days, otherwise practically all staff specialists. We also have some clinical academics. I'm one of that rarer breed.

Q. Do the VMOs contribute to the supervision of those trainees in the clinic setting that you have described?
A. The advanced trainees attend some of the clinics of the VMOs, and in that setting, then, purely from a clinical point of view, the VMOs contribute to that training; that's correct.

Q. In paragraph 11 of your statement, you tell us that there are three accredited advanced trainees in the department; correct?
A. Yes.

Q. And I think in an answer you gave a moment ago, you said that the cycle is yearly, so there will be three new trainees each calendar year, if I understood you correctly?
A. That's typically the case. Now, I will just comment briefly. There are two very similar training positions and there is one a bit different. Two of them are called required clinical years, very extensive breadth and depth of training. There is one position called a core year which has less breadth and more depth.

It is possible for an advanced trainee, for example, within our department to undertake two consecutive years of training in two different positions, but normally the case, and what is encouraged, is that the advanced trainees would undertake one year of training out of their three at one site and then move to another site. This is within endocrinology, but I think it's generally reflective of many medical disciplines.

Q. I'm just going to ask you some general questions about the selection and appointment of those trainees and if you need to distinguish between the two in the way that you

just have, please feel free to do so. But are you familiar with the process of how the trainees who might start, let's say, January 1, 2025, would be selected to those three positions?
A. Yes, I am, and I'm a member of the centralised selection panel for the advanced trainees in endocrinology. Most hospitals in New South Wales will have representatives on that selection panel.

Q. If we take it from step by step, what's the process for a doctor to become - start in the program in your department, say, of 1 January next year?
A. Certainly. So a doctor needs to make a formal submission to be considered for advanced training in endocrinology, and that is to the centralised selection process. Now --

Q. Just pausing there, the centralised selection process is a process conducted by NSW Health?
A. And ACT, yes. New South Wales and ACT Health. Once that submission is made, then there is a process by which the centralised selection panel have a pre-meeting prior to the formal day of interviews, determined based on their qualifications and experience which applicants will be short listed, and then they are interviewed, those applicants are interviewed, on the day.

Now, there is a somewhat dual process I need to talk about. There is a two-year contracted arrangement for advanced trainees, so those that are in the contracted arrangement, once they have done one year, they can discuss actually with the departments as to the second year where they might undertake their training. So that's approved by NSW Health.

However, all the other potential applicants are unable to approach the department, the heads of department, and for reasons of equity, for fairness, they place their written submission, the process of assessment and culling occurs at a centralised level and then they attend the interviews on the day which are late August this year.

Q. So this is a centralised process for facilities across New South Wales and the ACT?
A. Yes.

Q. So a doctor says, "All right. I want to go on the

endocrinologist training pathway"?
A. Yes.

Q. One applies through the centralised process.
A. (Witness nods).

Q. Say they are successful, what happens next?
A. Then on the day of the interviews, the provisional allocations are made for the advanced trainees who are successful across all the different hospital positions.

Q. Who decides where they go?
A. The combination of the priority listing from the centralised panel selection process and then the preference of the advanced trainees and what's called a matching process between the preference of heads of department of particular sites and the advanced trainees and - or advanced trainees to be.

Q. So you might have one trainee who wants to go to a facility, there is one spot, that's a relatively straightforward matching process?
A. Agreed.

Q. And you might have three in your department but 10 people who want to go there. That's a slightly different process?
A. Agreed.

Q. What involvement, if any, does the college have in this process?
A. The --

Q. As you understand it?
A. Yes, certainly. No, I was on the SAC in endocrinology so I'm trying to think back. The college is much more involved with accreditation of the particular training sites within the hospitals themselves. Then after that, I think to ensure that the process has equity and is transparent, NSW Health more so than I think the colleges, are directly involved with the selection process in that setting. So I think the college has relatively little involvement in the selection process, but I'm not as directly involved in that. So I think it's much more NSW Health than the heads of department.

Q. In paragraph 11 of your statement, you tell us that

there's currently three trainees, as we have touched on, but there is capacity to take a fourth?
A. Yes.

Q. Are you familiar with the process of the determination of whether it's three or four within your department?
A. Yes.

Q. Firstly, does that involve both the college and NSW Health?
A. Yes.

Q. Is the college side of the equation directed to accrediting the facility to have four training positions?
A. Yes. Would you like me to expand upon that briefly?

Q. Yes, briefly.
A. So, for example, with the site accreditation we need to complete a template - the head of department and the supervisory arrangements - as to what our current accreditation program is and then we can add a paragraph to indicate if we have the capacity to potentially undertake a further advanced training position.

The site visitors then, once the date is allocated, attend the site on behalf of the college and they make their assessment as to whether the site will be accredited - in this case, the department of endocrinology - and, if so, for how many advanced trainee positions, and they are given the capacity to make comment if they feel as though there would be an appropriate opportunity for another advanced training position.

That occurred about three years ago within our department, that recognition that there would be capacity for a fourth training position, which could work out well from the point of view of service delivery and training of our - of a fourth advanced trainee in endocrinology.

Q. And that's why you tell us --

THE COMMISSIONER: Q. So how precisely should I understand your statement when it says "if we were able to attract funding for a fourth, that would be 'optimal for service needs'", does that mean that it would be nice or does it mean that it's stronger than that, it's actually needed to meet the medical demand?

A. Thank you, Commissioner. The direct answer is that it would be nice rather than essential. We have a carefully organised triage system in which patients can be seen same business day if needed to help prevent hospital admissions. It would reduce the waiting periods for a number of - intermediate waiting periods of weeks and months for some patients in our system. It would expand the volume of the service that is provided under supervised conditions and would enable a further advanced trainee to be trained, when the ratio is about three to one in terms of doctors seeking advanced training positions in endocrinology compared with the number of placements across the state.

Q. That sounds slightly stronger than it would be nice but maybe just less than absolutely necessary?
A. Thank you. Thanks for that.

MR GLOVER: Q. So that's the college side of the equation?
A. Yes.

Q. What is your understanding of NSW Health's involvement in the process that would see an extra training place in your department?
A. So our approach has been to determine methods by which we can make a business case or a submission for funding for an advanced trainee in endocrinology, and over the years, we tried recurrently for a specialist advanced trainee post, an STP position, which had a rural and regional element to it as well as urban component within our department.

Even though we thought we had fashioned the submissions appropriately, we were recurrently unsuccessful, making the submission jointly out of RPA Hospital and a rural and regional site.

We had an example about - just before COVID where we obtained a temporary further 12 months advanced trainee position from an internal medicine doctor who was keen to undertake dual training in internal medicine and endocrinology. The funding largely came from the Dubbo area, they had the majority, 100K plus funding, and then we negotiated with our executive at our hospital that we would take a hit on one of our accounts and balance that up in terms of other budgetary needs within our cost centre.

So we do have a precedent there of a fourth advanced trainee but for a one-year period only, and that was specifically within diabetes training. So, sorry for that further part, but maybe it added clarification.

Q. So the need to attract funding that you speak of in paragraph 11 is a need to attract funding from within the NSW Health system?
A. And typically through our local health district and through our executive, unless we can realise one of the opportunities for advanced training that come up in advanced training post rural and regional health.

MR GLOVER: Thank you, Professor. I've no further questions, Commissioner.

THE COMMISSIONER: Q. Can I just ask again perhaps a naive question, but I will ask it anyway: is the demand for the services, health services, that are provided by endocrinologists something that's increasing?
A. The short answer is yes, because with an ageing population - many of our conditions are strongly age related. So, for example, diabetes; osteoporosis; to a degree as well obesity is age related; and then the cardiovascular and kidney complications, et cetera. So overall, within ageing, that specialty, yes.

Q. Ageing and lifestyle related are they?
A. Both, yes. Thank you.

THE COMMISSIONER: Nothing emerged out of that?

MR GLOVER: No.

THE COMMISSIONER: Do you have any questions?

MR CHENEY: No, Commissioner.

THE COMMISSIONER: Thank you very much for your time, Professor, we're very grateful. You are excused.

THE WITNESS: Thank you, Commissioner.

<THE WITNESS WITHDREW

THE COMMISSIONER: No-one should think there is anything dramatic in this, there is not, it is just to request some

help, but it's best I do it not on the transcript. Could I just have a five-minute meeting with all counsel in my chambers when we adjourn. That can include counsel that weren't at the Bar table, there's enough room, and listening online, if they are, but it's just to discuss some help I want. So if we could do that, it should only take five minutes.

Is there anything else for today?

MR MUSTON: No.

THE COMMISSIONER: All right. I will see the barristers in my room, I should say, shortly.

AT 4.17PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED ACCORDINGLY

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