Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

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

Tuesday, 23 July 2024 at 10.00am

(Day 037)

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

THE COMMISSIONER: Good morning.

MR FRASER: Good morning Commissioner, the next witness is Dr Nicholas Spooner, the current president of ASMOF, the Australian Salaried Medical Officers Federation. He's on screen.

THE COMMISSIONER: Okay. Dr Spooner, hello.

DR SPOONER: Good morning. Thank you for having me.

THE COMMISSIONER: No problem. The screen has frozen but we can hear you. Can you hear me?

DR SPOONER: I can hear you.

<NICHOLAS ALEXANDER SPOONER, sworn: [10.01am]

<EXAMINATION BY MR FRASER:

MR FRASER: Q. Dr Spooner, can you hear and see me?
A. I can hear and see you.

Q. Thank you. If at any time you can't make out what we're saying, please let us know. Thank you very much. Could you please give your full name?
A. It is Nicholas Alexander Spooner.

Q. Is it right you are currently the director of emergency medicine at Wyong Hospital; is that right?
A. That's correct.

Q. And currently the president of the Australian Salaried Medical Officers Federation; is that right?
A. Yes, that's correct.

Q. Dealing with each of those and then I will take you to some other things, firstly, when were you elected as president of ASMOF?
A. End of May, and then appointed by the registrar of the IRC in the beginning of June of this year.

Q. So you are in your second month in office, effectively?
A. Correct, very fresh.

Q. And can I also, in relation to your substantive

medical position, when were you appointed director of emergency medicine at Wyong?
A. That would be the beginning of last year, so about one year ago, and prior to that was the deputy director here for about three years.

Q. And your underlying appointment, is that right, is that you are a staff specialist in emergency medicine?
A. That's correct.

Q. And, of course, Wyong Hospital is within the Central Coast Local Health District; is that correct?
A. Yes, that's correct.

Q. Dr Spooner, you provided the Inquiry with a statement [SCI.0011.0249.0001] dated 17 July; is that right?
A. Correct.

Q. Have you got access to a copy of it, should you require it?
A. Yes, I do.

Q. And before giving evidence this morning have you read through it?
A. Yes, I have.

Q. Is there anything within it that you wish to change, alter?
A. Not at the moment, thank you.

Q. So it's true and correct to the best of your knowledge; is that right?
A. Correct.

MR FRASER: Commissioner, that will form part of the bulk tender in due course.

THE COMMISSIONER: Yes.

MR FRASER: Q. And just to round out a few bits of background, you tell us in your statement that prior to becoming a staff specialist, you completed most of your training in the Central Coast Local Health District; is that right?
A. That's correct.

Q. So overall, you've worked there in one capacity or

another, how long do you think?
A. About 14 years - about 13 years, from 2011. I think I said I'm the exclusive product of NSW Health from a medicine perspective.

Q. And in terms of your background prior to medicine, did you have another discipline or field of work before becoming a doctor?
A. Yes, I was an aerospace engineer in Canada and I did a masters in biomedical engineering in Canada as well and then took a fancy for medicine and have come to Australia to pursue that career.

Q. So you did your degree here as well?
A. My medical degree, correct.

Q. You tell us in your statement as well at paragraph 7 that other than your personal experiences at Wyong and within the Central Coast Local Health District, to extrapolate from that generally, you are speaking on behalf of ASMOF as well as yourself; is that right?
A. Yes, that's correct.

Q. The first thing I would like to take you to are what you have termed "current workforce issues", and I will take to you some illustrations within your statement at your local health district. You have said in paragraph 8 that it's your view that the current workforce model in New South Wales is outdated and is regularly unable to provide a sufficient workforce?
A. Yes, that's correct. So out of step with the current demand and even in its sort of suboptimal workforce modelling, we're unable to fill all the positions on the roster presently.

Q. We'll come back to the "why" in a moment. From your statement, before we go to the specifics, that's your personal experience as well as that of ASMOF; is that right?
A. Yes, that's correct, both.

Q. And at the moment we're talking predominantly about the medical workforce?
A. I would - yes, correct. Anecdotally my experience is similar across allied health and nursing, but there will be people who can attest to that with more credence than I.

Q. I will ask you now about the medical workforce, and we'll just get some terms locked down. You're a staff specialist which, for those - aren't you, Dr Spooner?
A. Yes, I am.

Q. That's right. And for those watching along who may not be aware, a staff specialist is an employed consultant; is that correct?
A. Yes, that's right.

Q. And you've also referred in your statement to visiting medical officers, otherwise known as VMOs; is that right?
A. Yes, correct. Yes, that's right.

Q. And your understanding is they are contracted consultants; is that right?
A. That's right.

Q. With contracts with NSW Health?
A. That's correct.

Q. And there are two types, you understand, of VMOs; is that right?
A. Yes, conventionally those who are on a contract with the hospital for a longer period of time and those who come in a locum capacity for much shorter stints, and the locum capacity often attracts locum agency fees and travel and accommodation fees as well.

Q. And within VMO, those with contracts, you have - although you are not one, you understand that some are contracted to provide on a sessional basis and some are on a fee for service basis; is that right?
A. Yes, that's correct.

THE COMMISSIONER: Q. Can I just ask you, Dr Spooner, in paragraph 9, you say there are multiple full-time equivalent positions vacant. In paragraph 10, you talk of 13 vacancies in the medical staff roster in the ED, and in 11, 10 full-time equivalent vacancies at the middle grade, ie, registrars in the ED. Can I just go back to paragraph 9. The multiple full-time equivalent FTE positions, are you referring to the positions you later, subsequently, refer to in 10 and 11?
A. Not exactly, and I would be happy to clarify.

Q. Yes, please do.

A. So in 9 I referred to full-time equivalent positions that are vacant, that's in the staff specialist roster, the very senior roster. Presently, at our hospital, there's roughly four or five FTEs vacant in my department.

Q. For staff specialists?
A. That's correct, yes.

Q. That's staff specialists in different disciplines?
A. Emergency.

Q. All in emergency?
A. Only in my department, in emergency. And in paragraph 10, this was in the midst of the COVID-19 pandemic, there were many days when our daily roster sheet showed the number of doctors who were coming to work in the emergency department on the day, where there were many, many, many blank lines, no doctor available to come to work.

Q. Was that because of the pandemic largely or a combination of other things?
A. It was multifactorial. The pandemic certainly didn't help with travel restrictions, and certainly geographically, the Central Coast and certainly the northern part of the Central Coast in Wyong is a challenging area to recruit to when workforce labour market is strained.

Q. Just before I come back to that, in 11, you're talking about a different set of vacancies; rather than staff specialists you're talking about the registrars?
A. That is correct.

Q. Right. Why is the Central Coast, do you think, a challenging area to recruit to?
A. I guess it's geographically pigeonholed between Newcastle and Sydney and those larger metropolitan centres have on offer, for people, urban attractions that sometimes outweigh the more regional centres, and when the regional areas are areas that can be developed from a residential point of view at a lower cost, that means that we have more lower socioeconomic status, more housing communities being built, difficult access to primary care where people are relying on hospital and the emergency department for many aspects of their care, so it is multifactorial but the gravitation --

Q. Do you mean, sorry, relying on the ED not just for acute care that it's meant for but for care that might ordinarily be provided by a general practitioner in a private practice, for example?
A. Yes, correct.

Q. I mean, tell me if you've got to guess and I'll still allow you to guess, but how much of your ED has patients that are coming in that could easily be seen or appropriately be seen by a general practitioner as distinct from actually having a condition or an injury that requires them to be seen in an ED?
A. Yeah,, it would be a guess, but I can get the numbers more definitively to you, but somewhere between sort of 10 and 20 per cent, I would say.

Q. Can you make a note to see if you can get that, the most accurate data you can for us, in relation to that?
A. Certainly.

Q. Before I ask you a question on another different topic, what in your view is the cause - I mean, there is perhaps an obvious reason but what's the cause of so many people presenting to your ED that could be seen by a general practitioner?
A. They are again, multifactorial. So obviously people need to seek their health care from somewhere when they are worried, in their time of need, they are going to go to a place that they know is open, they are going to go to a place that, in their experience, has all of the services in one spot.

If they do attend their general practitioner and they need blood tests or radiology imaging or some other consultation, that is done as an outpatient to and from the GP clinic, and you visit other medical sort of modalities. In emergency and in hospital we have access to all of those at our fingertips which makes us very attractive for those who have engaged with the health system in another way and felt that it was clunky and inefficient. Coming to the ED where we have everything is particularly efficient, but the waiting times become challenging when we're trying to process so many patients. But certainly the attraction is all the modalities in one spot with an emergency physician and other consultants available for advice.

Q. Bearing in mind your position, do you still get to know the GPs in your general geographic area?
A. Not as much as we would like and not as much as in recent past, which is unfortunate and frustrating.

Q. Is there a reason for that?
A. I would say work intensification across the board for everyone means that those human factors are put to the side.

Q. Do you know whether the GPs in your general geographic area - do they have their books full? Do you know if there are enough GPs to meet the demand for general practitioner type services in your area?
A. My anecdotal experience is the answer is no, patients are often - when we say "You'll need to follow up with your GP for this", they retort that they may find that challenging to get into at short notice.

Q. And could I ask you, in paragraph 9 you say, "Despite determined attempts to attract and retain staff to fill" the position you are discussing - what are those determined attempts? Can you give me some idea?
A. So the options that we have available to us are to put out applications to go to the labour market and see what's out there for all facets of fractions, so you could work as a 1 FTE fraction, you could work in a 0.5, you could work whatever suits you. We can do that as a VMO, we can do that as a staff specialist. We are particularly flexible, certainly in this labour market, to take whatever we are able to get that satisfies the requirements and even despite that we are unable to fill all of our positions.

Q. I know I did ask you before but do you get feedback specifically in relation to those attempts about why you can't fill those positions or is it the same answer you gave previously to a similar question?
A. Yeah, rarely do we get feedback. Mostly it's just a limited pool of applicants.

Q. And can I ask you, are these positions advertised on the LHD's website or --
A. They are advertised broadly, consistent with the district's approach for advertising, and that's oftentimes in journals, oftentimes electronically through the college that the position is associated with so we - and those come at expense as well, so we attempt to engage in all the

common-day reasonably productive modalities to get us the best set of recruits or set of people who are interested, candidates.

We also use sort of internal comms between different departments and different LHDs to put the feelers out for people personally to ask their friends or other groups they may be on to message, to get the ads out.

Q. And what's the consequence of having the level of vacancies you have mentioned (a) in relation to staff specialists; and then (b) if it's a slightly different answer, in relation to registrars?
A. So I guess globally, if you are trying to do the work that is necessary and give the care that is necessary and you don't have the resources required to do that, you either have to have intensification of work, which impacts fatigue and morale and culture, and that's sustainable for a small period of time, we all know that we can work hard for a short time, but it's not indefinitely sustainable and then something's got to give.

The alternative, which is somewhat even more frustrating, is you're unable to give the care that you would like to give because you don't have the resources that you need and then patients suffer and then, obviously, the second victim syndrome of the staff suffering because they knew that they couldn't give morally what they knew was right to patients because of the resourcing challenges.

Q. What do you mean specifically by you can't give the care you want to give. Does it mean there's more time to wait for the patient or does it mean something beyond that?
A. It is both. So initially, what happens is time. People who can wait, do wait, and that's the nature of the triage system for emergency engagement. People who can wait, do wait.

Then, subsequently, when the resources are even more stretched and the acuity is high for several patients, it means that some patients may get a delay to care that we would like to see them have more urgently and that's insidious in its beginning and then becomes - when the resources are stretched further, that becomes even more identifiable, delays, whether to medications, delay to could be antibiotics, it could be analgesia, it could be consultations of a specialist, it could be transport to

another hospital for definitive care when there are many, many competing interests. Unfortunately humans can only do one at a time, and if we don't have enough people to do one at a time for every person then somebody has to wait and they may be waiting for something that's emergent.

Q. So there are at least four factors, there might be more, but three for the medical professionals, one is becoming fatigued and stretched, I will just use that term.
A. Yes.

Q. And secondly, then there's the general concern as a medical professional that provides health services of not being able to give perhaps the quality or timely care you want to give; and then there's at least two consequences for the patient. One is having to wait longer than perhaps is desirable, but also for those patients that have a more acute need, a delay in providing that acute level care that, the preference, at least from the medical practitioner, is that they are given it earlier?
A. That's correct.

Q. Is that a general --
A. That's correct.

MR FRASER: Q. Just to clarify a few things about the size of that deficiency, you said in answer to some questions from the Commissioner that you currently have four or five FTE consultant level positions vacant?
A. In Wyong emergency, yes, and that's one of many, many, many departments across our Central Coast and the NSW Health.

Q. Indeed, and I will come to that in a moment, just to put that in terms of the scale, how many consultants do you have positions for within the ED?
A. So my established FTE is roughly 19.5. That's rounded to 20.

Q. So between 20 and 25 per cent of your consultant positions are currently vacant; is that right?
A. Correct.

Q. And you have spoken in paragraph 11 of 10 FTE vacancies at what you've termed the middle grade, and let's just clarify that. When you term registrars, you're differentiating them obviously from consultants at the top

end; is that right?
A. No, registrars - consultants sit outside the registrar cohort, the middle grade cohort, so --

Q. Yes, but when you say "middle, what are they in the middle off? Junior medical officers at the bottom; is that right?
A. Yes, correct, JMOs - junior medical officers - at the bottom and consultants at the top, yes, correct.

Q. Yes, that's what I was coming to. And in terms of registrars, how many FTEs are in your established structure?
A. Roughly 30 --

Q. So you are missing approximately --
A. -- in the ED at Wyong.

Q. In your ED, so approximately 30, 33 per cent of --
A. Roughly, yes, correct.

Q. And just in terms of how long that sort of scale has been the case, you tell us in your statement - and I know you've only been the director for a year, but you have worked in the ED for at least five years; is that right?
A. Yes, correct, and then for several years before then as a trainee, correct.

Q. How long has it been that size of a deficiency in your vacancies?
A. At least since my time as an emergency physician, so at least five years, and probably then some, and just slowly the gap growing.

Q. Thank you. You've made the point that this is within your department within your particular hospital. You've made some illustrations in paragraph 11 of some of your colleagues within the local health district - 10, a similar number as you, 10 FTE vacant registrar positions at Gosford ED?
A. Correct.

Q. And you also have indicated an understanding of 4.5 FTE short in obstetrics and gynaecology. Is that across the district or a particular location?
A. That's across the district and that's from my ASMOF experience.

Q. And just putting your ASMOF hat on, is it your understanding that these shortfalls are replicated in other places?
A. That's certainly my understanding.

Q. Can we just come back --
A. And I would just clarify that it's probably more disparate in the regional and rural areas as compared to urban, but certainly that's ubiquitous - shortfalls are ubiquitous across the state.

Q. And one exception, perhaps, to that is that which you have highlighted at the end of paragraph 11, which is the shortfall in psychiatrists at the Western Sydney Local Health District; is that right?
A. Correct. Psychiatry on a whole is about 25 per cent under-recruited and some of that is disproportionately in certain areas of the state, who are feeling the brunt, correct.

Q. Out of interest, do you know what the position is in your local health district for psychiatry?
A. I do not know, I'm sorry.

Q. That's all right. Now, in your statement you have spoken of the efforts to fill those gaps. You have spoken already to the Commissioner about the different modes of attempt, advertisements, in an attempt to recruit to positions, and I think in answer to a question from the Commissioner you've said generally, just not sufficient applicants of the required standard to fill all the positions; is that right?
A. Correct.

Q. And in paragraph 12 you give an example of that of a four-week period in May 2024 where there were, according to your statement, 45 vacant consultant shifts within the medical staff roster in your ED?
A. Correct.

Q. And you sought to fill those with either VMOs or locum staff?
A. Correct.

Q. And you managed to fill just over half.
A. That's right.

Q. Is that representative of your experience sort of month to month?
A. Yes, it is. And I would just also add that the workforce modelling that we are trying to fill is out of step with the current demand as well

Q. I'll just take you to that. You dealt with that in your statement. When you say "out of step", can you tell us what you mean by that?
A. So the workforce models that are put in place about how many staff we should have in order to deliver a service are based on estimates of population growth and demand coming to the hospital and through each of the departments across all of the state. And the strategic plans for districts are put in place to try to address what they expect demand to look like over the coming three, four or five years, and in our experience, the workforce models that have been funded are not in step with the demand that we are actually seeing, so they often - there is a more conservative approach to what the workforce models are funded to rather than what we are seeing as populations increase and presentations grow.

Q. Just because it is illustrative, you have dealt in your statement at paragraph 25 with a model that is for emergency departments that has been compiled or authored by your college, the Australasian College For Emergency Medicine; is that right?
A. Yes, that's correct.

Q. We'll just put that up on the screen, if we may, [SCI.0011.0242.0001]. Hopefully that will come up. It's referred to as the G23 guidelines. You are not a contributor to this document, are you, Dr Spooner?
A. I have not.

Q. But you are familiar with it, presumably?
A. I am.

Q. And in terms of its - in your opinion as a director of emergency department, do the numbers seem generally about right, in your opinion? We'll come to --
A. Yes, and the incredible amount of work that the college has put into that, I feel very comfortable with it.

Q. If we just come to, because we've been talking about

Wyong, if we go to page 7 of that document, on that page it deals with recommended levels of medical staffing for emergency departments --
A. Yes.

Q. -- on that page and over. And per shift. It's split into three shifts - day shift, evening shift and, over the page, night shift. Is that the way that your shifts are split?
A. Yes, correct, day, evening and night.

Q. Thank you. It's formulated on the basis of emergency presentations per annum in the left-hand column, and if we look at the day shift, for example, approximately how many presentations are at your ED?
A. I would say just under 80,000. This year we may very well go over 80, so - but to be conservative, we should be looking at between 65,000 and 80,000 for my emergency department.

THE COMMISSIONER: Can I just ask you, I can see this on the screen, but can you tell me where it is in the bundle?

MR FRASER: Yes, Commissioner, it is behind - it is H --

THE COMMISSIONER: I have H1 and H2, both of which have multiple volumes.

MR FRASER: H7.7. It's directly behind Dr Spooner's statement.

THE COMMISSIONER: Here it is, sorry, yes. I've found the volume. Yes, I have that, thanks.

MR FRASER: And we're on page 7, Commissioner.

Q. So this table, Dr Spooner, provides recommendations at the different levels. If we can just deal with that, "Expert" or "FACEM" - those are your consultants; is that right?
A. Correct.

Q. And the more junior doctors are split into three levels, advanced, intermediate and basic. From what you said, we were discussing earlier, is it right you divide those doctors into two in your --
A. Yes, correct. That's the way that we do our

modelling, but I anticipated you would like to talk about that and I'm happy to talk about it in the capacity that we can see it on the screen.

Q. All right.

THE COMMISSIONER: Q. The term "modelling" that's being used, can I just ask, the document we're looking at, the "Constructing a Sustainable Emergency Department Medical Workforce", is this document the result of some form of simulation or predictive modelling or is it more a guideline as to the medical staffing that might be needed for an ED depending on how many presentations there are in a year?
A. I suspect the latter. I was not specifically involved in it. Predictive modelling analytics, if you're referring to more analytics might be --

Q. Those sort of analytics would be more likely to be used where you're actually looking at a specific population and you've got the data about its age profile, socioeconomic demographics, you know, levels of chronic disease - all those sorts of things - where you might then feed that into a model and say, "This is what we're likely going to need", because there might be a population of 100,000 in a certain area with all of those certain demographics that might have far less or far more presentations to an ED than another population of 100,000 because of different age profile and other things I mention; correct?
A. Yes, correct.

THE COMMISSIONER: Okay.

MR FRASER: It is a blunter tool, Commissioner.

THE COMMISSIONER: Yes, that's not a criticism, because it's a general thing, it's not looking at a specific population as far as I can gather, having seen this document two minutes ago for the first time.

MR FRASER: Q. Dr Spooner, if we just work our way across, the 65,000 to 80,000 line, this recommends five consultants on a day shift. How many do you have --

THE COMMISSIONER: Which table am I looking at, 6.1?

MR FRASER: Table 6.1.

THE WITNESS: Yes, so we have roughly 2.5, and I know that sounds like a strange number - sorry, 3.5. That sounds like a strange number. We have a shift that crosses over between day and evening to help to capture the time of day that has more patients presenting.

MR FRASER: Q. I think in your statement you've referred to two. Is that two at the beginning but picked up with some more with the crossover; is that right?
A. That's correct.

Q. And in terms of the more junior doctors, it recommends 11 in total, but made up of those levels. What is the position at Wyong on a day shift?
A. Roughly nine. And I would just reiterate the challenge is that's what we are funded for, but we're unable to fill those positions, so what we actually see on the floor is not even what we are funded for.

Q. And how many vacancies of that might you have?
A. Sometimes one or two a day and sometimes up to five or six and sometimes during COVID - and I appreciate that was a long time ago - sometimes up to 13.

Q. That would leave you with no-one.
A. Across the whole day, I'm sorry.

Q. Across the whole day, I see.
A. Yes.

THE COMMISSIONER: Q. Can I just ask you, in paragraph 24 of your statement where you're talking about predictive workforce modelling, in the last sentence you say:

> *... I believe it is viewed as something of a novel concept by NSW Health.*

I want to ask you what the basis of that belief is, but before I do, predictive or simulation modelling is not new science. I know that from having worked for a bookmaker many years ago and an interest in horse racing. I know predictive modelling is not new science, not that there's a ready analogy to health care, but this isn't new science. What is the basis of your belief that it is a novel concept

to NSW Health?
A. Some years ago I did ask myself if we had a bucket of money or access to extra nursing staff or access to extra doctors, I asked myself where would the best place be for them to go to work, should they go and work in nursing homes to get patients out of hospital; should they go to work on wards to get patients in the hospital from the emergency department; should they work in the emergency department? And I asked myself - I didn't have the capacity just in my own brain to figure out where the best place was for them to work and I thought, as you've inferred from bookmaking or horse racing or manufacturing and what-not, there may be a way to try to do where the best cost-effective place for them to go to work was.

And so I was curious about that, and asked through our executive channels whether or not we had any - had been doing any or whether or not that was a thought about predictive analytics and the answer was no, we hadn't, that there was none of that being done presently.

Q. I think I know the answer to this but I'll ask it anyway: would you see a benefit in that sort of predictive simulation or modelling being done for different LHDs on the basis that some are going to have similar demographics for their populations but others might have quite different, which those sort of modelling tools might be of an advantage to work out what workforces might be needed, as an example, in EDs?
A. I guess the pragmatic answer is if there - sorry, the answer is yes. We should explore the options to ensure that we're using our resources as efficiently as possible. I guess the pragmatic answer is if the resources aren't present, then is that an exercise in futility, and that's rhetorical. Of course, we should try to gather more information about how we should use our existing resources.

Q. I mean, I guess past patient number presentations from the year before to an ED are a reasonable guide as to what the following year is going to be, but depending on demographic changes such as ageing and such as advancement of chronic disease, the previous years or five years ago may not necessarily be a completely accurate guide to either the next year or certainly not the next - you know, in five years' time. Would you agree with that?
A. Obviously the predictive - the extrapolation beyond - the further you go out with extrapolation it will be less

accurate, but when we're talking about where we could put a few nurses now or a few doctors, I think the information could be reasonably accurate when you're thinking about it over the short term.

Q. In the short term, yes. But the longer term, not necessarily, because --
A. Mmm, yes.

Q. -- stationarity isn't a great guide for the future?
A. Correct. But also there isn't great - there are certainly differences in different areas, LHDs and postcodes, but the postcodes don't change their demographic as rapidly - don't change it as rapidly, I can say.

THE COMMISSIONER: Okay.

MR FRASER: Q. I think in terms of your current establishment, you tell us in paragraph 27 that your understanding is that your current staffing model was a 2018 - arises from 2018; is that right?
A. The strategic plan has probably been updated but some of the workforce modelling that we have been working for and advocating to enhance for many - several years is outdated. I can get you the specific dates, should you need them.

Q. I might just take you back now very briefly at paragraph 14 of your statement, just in terms of locums, locums are obviously, you've said, one of the means you try to plug the gaps, at least in your rosters, at least on a short-term basis?
A. (Witness nods).

Q. In terms of the questions from the Commissioner, you have explained some of those efforts. In paragraph 14 you deal with some of the additional costs and restrictions on locums.
A. Yes.

Q. Just to put it in context, how many locums, say consultants, do you tend to have at any one time? Presumably it varies, firstly, depending on who you can get your hands on?
A. Yes, correct. So there are probably four or five who are regular and probably another four or five who come and go, so perhaps 10, but if you wanted a more specific number

I could try to get it for you.

Q. No, that's suitable. And similarly, are they similar sort of numbers for your more junior medical staff?
A. There are certainly more locums participating in the junior medical staff area.

Q. Just dealing with the junior medical staff, you've outlined at paragraph 15 an issue you've identified, I just want to ask you some questions about that, about the ability of junior doctors to work as a locum. You've said in your statement more - and when I say "junior doctors", I'm referring to registrars, and perhaps I should say that, registrars. They're not allowed to work as a - able to work as a locum within their own local health district, they have to go to a neighbouring health district; is that right?
A. Correct.

Q. Although they can undertake casual work, casual shifts within their local health district, but not at the same rates as they would be able to obtain as a locum; right?
Dr Spooner has frozen. Can you hear us, Dr Spooner?

MR FRASER: I will take that as a "no", Commissioner.

Commissioner, we're just going to try to make a call to Dr Spooner.

THE WITNESS: I have come back. Every one of my computers has just turned off so I am back on my phone.

THE COMMISSIONER: Fantastic. Can you hear us?

THE WITNESS: I can hear you, yes, thank you. Apologies.

THE COMMISSIONER: We can hear and see you.

MR FRASER: Thank you. No blue screen of death, Dr Spooner?

THE WITNESS: It must have been ClickShare, or whatever it was.

MR FRASER: Q. I was asking you about junior doctors and their ability, whilst they can work casually, they can't work as a locum within their LHD. Can I ask you this,

Dr Spooner, are there currently junior doctors that you're aware of, or registrars that you're aware of, within your LHD, that have indicated they would undertake locum work within the district if they were able to be paid at locum rates?
A. I couldn't name them by names but yes, absolutely, there are many people who have capacity for extra work, and junior doctors must leave the LHD to do extra work if they chose at the locum rates.

Q. At the locum rates. Do you currently have any junior doctors from your LHD that pick up casual shifts at that lower casual rate?
A. Very rarely.

Q. And you have highlighted, in your opinion, some of the efficiencies that might arise if your junior doctors were from the LHD. Do you find that locum registrars that come to you are sometimes missing aspects of local knowledge?
A. Certainly. There is obviously, as you would know, a period of on-boarding for anyone to start a new job. That's well known in the workforce market, and prescribing people to work outside of the area - outside of the district or outside of the institution they already are on-boarded into is a resource drain, poor utilisation of resource.

Q. And you've also explained that locums - at paragraph 16 - generally will be contribute to the overall running of the department in the same way as longer-term staff?
A. So certainly locums do not engage in any aspect of clinical governance traditionally. There are LHDs who do use VMOs to do clinical - non-clinical work, clinical governance work, heads of department managing morbidity and mortality meetings, management clinical practice meetings, managing complaints, and traditionally that's in areas that find it even more challenging to get permanent staff and they must - because clinical governance is a pillar of quality health care, we must do clinical governance, and if we can't find permanent staff to do that, then we must look at alternative models to do the clinical governance.

Q. Those VMOs that you're referring to, those would be VMOs working within a local health district for lengthy periods under contract as opposed to doctors coming in for short-term locum work here and there; is that right?

A. That would be - yes, correct.

Q. I want to ask you some questions about your impressions of - you've said at paragraph 8 that it's ASMOF's position that the issues about attracting staff are, at least largely in your opinion, due to issues with the staff specialists award.
A. (Witness nods).

Q. I'd like to ask you some questions about the award, but before I do so, what is it that informs that opinion that the award is a significant contributor?
A. I guess the award - so firstly, my anecdotal experience as a department director, trying to engage with medical workforce units, identify the barriers to finding the adequate staff, we frequently come up against the challenge that that's outside of the remit of medical workforce, it's an award barrier, we can't pay people more, we can't offer them other attraction retention carrots to get them into the department, so - because it is at the award level where some of the challenges are.

And the issues with the New South Wales award is it's out of step with the other states' awards and that means that the labour market is defined by the rest of the country. If there are more attractive both financial and human factors award conditions, people will look elsewhere for where they would prefer to be employed, and my opinion, and the opinion of ASMOF, is that the award is one of the - perhaps the largest - barriers to the workforce crisis.

Q. Just in your personal capacity just before we come to the detail of the award or some of the detail, are you aware, within your discipline, of emergency physicians who have chosen to work elsewhere because of pay and conditions in another state?
A. Mostly it's just the absence of people on our roster that would speak to that, rather than people saying, "I'm going leave to go to other states." Traditionally, the word of mouth is that when medical students graduate and when specialists graduate from their college, they have a choice there about their career path and progression, and at that point, if you don't have an attractive place to work from an award or a culture or a morale perspective, then people aren't going to tell you that, they're just going to go and work somewhere where they feel they're valued and appreciated the way that they feel is right.

Q. Do you have specialist training - do you have trainee emergency physicians at your hospital?
A. Yes, we do.

Q. Do you gain any impression from them about their future intentions?
A. Locally we do a pretty good job of retaining our local talent but there are people who come and go, so perhaps a third, or something like that, is just what feels right to me; we might get it a third of them to stick around and others go on to bigger and better things and whether or not that's a different institution in NSW Health or whether or not that's an institution outside of NSW Health is not - I'm not privy to that.

Q. At paragraph 29 you have dealt with remuneration. I don't want to spend too long on that, those figures are easy to obtain, but it's your understanding that currently, staff specialists are paid less than in any other state or territory, according to your statement?
A. Yes, correct.

Q. And you go on to say that other similar awards had undergone reform by about last year, that have changed the picture?
A. Look, correct, recently, yes.

Q. And, of course, you note that those awards continue to evolve, and no doubt remuneration is reviewed on an ongoing basis, increasing what you term --
A. That's correct.

Q. -- "the gap"? I'd like to ask you about some of the conditions in a bit more detail, however. You have flagged a number in your statement. I'd like to ask you firstly about on-call work, or periods on call. You deal with that starting at paragraph 34. You are required under the award, without taking you to it - staff specialists are required to be available to undertake a reasonable amount of on-call work; is that right?
A. That's correct.

Q. And as you go on to identify - and there is provision, as you understand it, there has been provision for that to be remunerated on a flat basis, is that right, for all staff specialists?

A. That's right.

Q. And you note in the following paragraph that it doesn't matter how much you actually do, you are paid the same?
A. Correct. And so the evolution since the inception of the special allowance for on call is such that the nature of modern-day care has changed and the quantum of on call and the responsibilities of on call have changed, so that they don't reflect how - what - the basis that that was established on and as you said, it's a flat rate. So those who do more on call, based on short staffing or based on their specialty or based on their feeling that they should return to hospital, that doesn't reflect the current work requirements and work intensification that has happened since that was instituted into the award.

Q. To take your department as an example, you said earlier that you're four or five consultants, FTE consultants, short on your establishment. Presumably that - does that translate to a greater on-call load for those staff that are there?
A. Yes, it does.

Q. What's your current on-call arrangement for your staff specialists?
A. We would just divide the number of days by the number of staff, and we aim to get an equal distribution of on call so that no-one feels that they are being besmirched by some aspect of rostering.

Q. So if you're able to attract additional staff, that lightens the load on everyone?
A. Yes, correct. Correct.

Q. And the other fact, as you've just been talking about, the nature of on call, as an emergency physician, how has that changed?
A. I would probably say that the better examples of that are for the specialists - the physicians and surgeons who are on call to take calls from home, to give advice, to consider whether or not they must return to hospital. The workforce changes have led - and the modern day ways that we can access EMR and radiology and pathology at home mean that rather than an on call being a simple phone call and some advice, it now turns into what one might call sort of a virtual consult or a virtual review, where their

expectation would be, if you can access it, that you should pull up the notes and pull up the pathology and pull up the radiology, which changes a few-minute advice phone call into a more laborious endeavour. With the quantum of calls that means that instead of one or two calls a night, that may be on the order of, you know, 10 to 20 calls a night, and so that has changed for consultants who spend their time out of hospital, rather than emergency physicians who are there almost up until midnight and then some.

Q. And you have given some examples of that in 35 and 36.
A. (Witness nods).

Q. I just want to ask you, back at paragraph 33, a question about - you've given an example in relation to overtime for staff specialists. I'd like to ask you about that. You've said that currently there's no capacity in the award to be paid for overtime work between midnight and 7am. Firstly, when you say "overtime", what do you mean by that?
A. Yes, if you were rostered on a shift that was meant to finish at midnight but there was other parts of the shift - other parts of patient care that you had to tidy up and you were going to stay longer, or if a sick patient arrived just towards the end of your shift and you felt that it was necessary in order for patient care and safety to stay behind, then the award essentially turns off at midnight and there's no way for you to be remunerated for that. Appreciating there is the on-call allowance, so one could make an argument that you were called in, but you never left the hospital, you just stayed. So that's the sort of expectation now is that would be you're called in.

But there is only one person who is on call, at least in the emergency department, for the overnight period, and anyone else who wasn't on call would not be sort of earmarked that special allowance for that period of time. So after 12 o'clock, there is no way for you to make a claim under the current award.

Q. And how often would this happen?
A. I guess it depends. Knowing that there's no way for you to make a claim would mean that people would adjust their behaviour to try to avoid getting into that time continuing to do work and having no capacity to be remunerated for it. So it's not particularly common for people to stay back regularly, because they work that into

the way that they work, but when there are times when you need to stay back, that leads to an element of resentment - it can lead to an element of resentment.

Q. The last area I want you to ask you about is leave and related entitlements. Firstly, what's known as TESL or training, education and study leave, I believe?
A. Correct.

Q. In paragraph 32 you noted that that's something that sits outside the award, in a separate instrument. But I would just ask you this: that leave is one of the benefits of being a staff specialist; is that right?
A. That's correct.

Q. And would you just tell the Commission how much theoretically there is available to be taken, if you can access it, or how much the amount is?
A. So it's roughly $35,000 a year and if you've seen the TESL document it's calculated based on price of airfares and cost of fuel and what-not to make sure that it remains comparable in order to access overseas conferences and other domestic conferences and travel to and from. And there's also earmarked 25 days of travel and education leave, and that's in the TESL document.

Q. Thank you. Is that --
A. I mean, at present it could be about 38,000, but it's in the document.

Q. Certainly. Is that, in your experience, something that staff specialists are able to fully access?
A. It depends on your - my understanding is it depends on the health districts. There are certain health districts which seemingly have made it more challenging for specialists to access that, and I'd probably best not get into the details here because I don't know them outright so I would be speaking out of school, but that is the feedback, certainly from an ASMOF perspective, that a large quantum of industrial cases that come through the union are to do with accessing TESL.

Q. And would it be right to say that layered on top of that is the basic difficulty, if you're in a department where there are currently staff shortages, that those pressures would limit people's ability to take that leave as well?

A. Yes, correct. So essentially, you would see a moratorium on leave over certain periods where the workforce got to a level that we could not provide at least safe care or the semblance of safe care, and you would start to tell people they couldn't go on leave, as the department director, to ensure that you had maintained some level of safe staffing, as best as you could surmise, and that would mean whether it was annual leave or TESL or long service leave, and then that becomes a conversation amongst the department, amongst the employees and the employer to figure out how we navigate that, which can be challenging.

Q. And presumably the same issues arise in relation to annual leave; is that correct?
A. Yes, correct.

Q. In your experience, how does that impact on - other than the fact of people not being able to take it, how does that impact on staff?
A. I guess it's probably again multifactorial. If we are more lenient and allow people to take more of their award based leave, then the employees who remain on the roster over those periods of time may feel like their work intensifies and they get more fatigued and be frustrated about too many people taking leave, and if you have - and the flip side of that is if you enforce a moratorium on leave for certain periods, then people are frustrated and resentful that they're unable to access their award-allocated leave, and so the expectation is to walk that line with your department, which is challenging in the face of workforce crisis and award allocations of leave that people feel, and rightfully so, that they are entitled to take.

Q. There was one last issue, and that's in paragraph 40, I wanted to ask you about, and that's an absence of a condition in the award. You touched on safe staffing levels at paragraph 40.
A. (Witness nods).

Q. What do you mean by that? Just to explain the term.
A. Yes, okay, super, thank you for asking. So I guess as an analogy we've all seen the G23 document today, and if the consensus and understanding is that these are sensible or safe staffing levels for a department that's doing that quantum of work, is there a way in the award to enforce that those doctors are present on the shifts, if we have an

understanding that that is what we feel is necessary to deliver the world-class health care that we are ascribing to, then how do we enforce that we are able to access those staff? And presently there is no safe staffing mechanism in the award to ensure that we have the staff that we feel is right to deliver the service that we are advertising.

Q. Just related to that, just to ask you your understanding, is there any provision for maximum workloads within the award?
A. No. Terms like "reasonable" are used, and that varies - that can vary, obviously, depending on what you have been indoctrinated to, what system you are in, what the morale and culture is of your workplace, but there are no safe or maximum workload mechanisms in the award.

Q. I take you back to your example of reasonable, the on-call requirement is one of reasonable on call, but there is no maximum amount of on call specified within the award; is that right?
A. That's correct. And "reasonable" is obviously open for interpretation and it's even open for interpretation by the clinician: is it reasonable to return to hospital for the X number of children that you may need to see because you felt they were sick and unwell? It would be reasonable morally for you to want to do that, but is it reasonable to be expected to do that over and over and over, and the answer may be, "Yes because that feels right to me", or it may be "No, I would like to be valued and remunerated for that and have a mechanism for the health system to show me my worth from that capacity" - so both internal and external reason, if that makes sense.

MR FRASER: Commissioner, those are the questions I have for Dr Spooner.

THE COMMISSIONER: Q. Can I just ask you, if you know, sticking with paragraph 40 of your statement and the discussion you have had with Mr Fraser about the staff specialist award, do the equivalent awards in any of the other states, to your knowledge, have any provisions in relation to safe staffing levels?
A. Not to the best of my knowledge. Some LHDs for inpatient teams have implemented, for instance, the number of patients that one team could be expected to look after. So that's not intrinsic to an award, and no mechanisms, to the best of my knowledge, in any other state's awards, but

the thought that we are exploring is implemented in some capacities, certainly for inpatient teams.

THE COMMISSIONER: Thank you.

Mr Cheney, do you have any questions?

MR CHENEY: Commissioner, could I ask for a couple of minutes just to take some instructions on matters? At the risk of detaining Dr Spooner.

THE COMMISSIONER: It might be convenient, then, to take morning tea now to give you a bit of extra time, even though that slightly inconveniences Dr Spooner.

Dr Spooner, Mr Cheney, who is the senior counsel for health, has just asked me for a few minutes to consider whether he needs to ask you any questions, and I will grant him that indulgence. Because it is 11.15, I'm sorry, we'll take the morning tea break, if you don't mind. It will only be 20 minutes and then we'll come back and Mr Cheney might ask you some questions.

So it's 11.15, around about, now, so we'll come back at 11.35. So we'll adjourn.

MR CHENEY: If I have no questions, Commissioner, I might let my colleagues know.

THE COMMISSIONER: If Mr Cheney works out that he doesn't need to ask you anything within five or 10 minutes, we'll let you know so that you can go about and do the rest of what you have got to do today. Otherwise, we will adjourn until 11.35 in any event.

THE WITNESS: That's lovely. See you then.

MR CHENEY: Thank you, Commissioner.

SHORT ADJOURNMENT

THE COMMISSIONER: Yes?

MR CHENEY: Thank you for the time, Commissioner.

<EXAMINATION BY MR CHENEY:

MR CHENEY: Q. Dr Spooner, you recall being asked some questions about predictive workforce modelling and particularly the reference in paragraph 24 of your statement to it being something that, as you perceive it, is not deployed by NSW Health. Do you recall being asked about that a bit earlier, sir?
A. Yes, correct. And can you hear me okay? I've just swapped computers.

THE COMMISSIONER: Yes, we can hear you, yes.

MR CHENEY: Q. Sir, I think over the break you were sent a link to a NSW Health website?
A. Correct.

Q. Did you have an opportunity to explore that link in the break?
A. No, I have not. I guess the - and can I clarify, is that a predictive analytics or is that workforce modelling?

Q. It's the part of the NSW Health site that reports on the nature of and the results of workforce modelling that it undertakes from time to time.
A. Yes.

Q. I just want to clarify whether, when you wrote paragraph 24 of your statement, you were aware of what is reported at that link?
A. Not in detail. My comment was based on my experience with our local health district about predictive analytics in particular, rather than workforce modelling. I think workforce modelling is attempted to be done. My question was, or my suggestion was, could it be even more nuanced, if the resources are such a valuable commodity.

Q. And by "nuanced" you mean more granular - that is, taken down to modelling of particular situations in particular LHDs; is that right?
A. Yes, and to try to ascribe if, for instance - my example was if you had four nursing FTE, where would the most useful place for them to be deployed be? My example was would they be best to be deployed into a nursing home where they could look after patients and get them out of the acute care hospital; or would they be better to be deployed into the wards or the emergency department or

short stay? And to the best of my knowledge, that information isn't available.

THE COMMISSIONER: What kind of modelling is this, Mr Cheney?

MR CHENEY: I think it's a matter of labelling, your Honour. I would have thought all modelling is predictive. This term "predictive modelling" has been used by Dr Spooner and by others, I think. But the site itself doesn't use that phrase, I think.

THE COMMISSIONER: It says:

> *Workforce modelling maps the current and forecast labour pool ...*

I guess we don't know, just based on this, what the inputs are and how it's done and what the algorithm is and all of that sort of thing.

MR CHENEY: I think when one goes to any particular subfield, such as medical modelling, more information is supplied about what the results --

THE COMMISSIONER: Having introduced it and asked the witness some questions about it, you will no doubt be informing us completely about the nature of this modelling in great detail so we look forward to receiving the information.

MR CHENEY: Yes. I was merely looking to clarify at the time paragraph 24 was written, that was known to the witness.

THE COMMISSIONER: Yes.

MR CHENEY: Q. Sir, can I clarify something about your evidence as to the state of FTEs vacant in your emergency department. Do you recall - this is at transcript 3838, line 4 - that you said presently at your hospital there's roughly four or five FTEs vacant "in my department", and you clarified that was for staff specialists in emergency. Do you recall giving that evidence earlier?
A. Yes, correct.

Q. Do you have paragraph 11 of your statement, sir?

A. Yes.

Q. Can I just clarify what you're referring to in the second sentence there where you say "in addition, we are one or two FTE consultants short"? Are you there speaking of staff specialists when you describe yourself as being one or two consultants short?
A. I'll have to clarify. I believe - and I'll just clarify - that's - I think I have referenced "per day" and --

Q. In your oral evidence you mean, sir, or in the statement?
A. In my statement I've referenced on a roster per day. And so what I - the challenge we have is that the workforce models don't always equate to what we see on the daily sheet when we turn up to work, and so if you're FTE short, what that ends up meaning is that on the daily sheet you see shifts that are vacant, and so that's what that is inferring or referring to, I should say.

MR CHENEY: Thank you. Nothing further, Commissioner.

THE COMMISSIONER: Thank you. Did anything arise out of that, Mr Fraser?

MR FRASER: No, Commissioner.

THE COMMISSIONER: Doctor, thank you very much for your time. We're very grateful and you are excused.

THE WITNESS: The pleasure was mine and thank you for the great work you're doing.

THE COMMISSIONER: Thank you, Cheers.

<THE WITNESS WITHDREW

MR FRASER: I will hand back to Mr Muston.

MR MUSTON: The next witness, who is just being collected, is Dr Rebecca Nogajski

MR CHENEY: Commissioner, might I be excused and leave Mr Chiu in the chair?

THE COMMISSIONER: Of course. You are going to get the

modelling, are you?

<REBECCA RUTH NOGAJSKI, affirmed: **[11.45am]**

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Could you state your full name, for the record, please?
A. Rebecca Ruth Nogajski.

Q. You are the executive director of medical services at Western Sydney LHD?
A. Yes.

Q. That's a role that you have held since February 2022?
A. Yes.

Q. I think you previously acted in that role for an extended period during 2021 as the, presumably, acting director of medical services?
A. Correct.

Q. You have prepared a statement to assist the Inquiry with its work dated 16 July 2024?
A. Yes.

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

Q. Have you had an opportunity to read it and refresh your memory of it before giving your evidence today?
A. Yes.

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

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

THE COMMISSIONER: Thank you.

MR MUSTON: Q. Your statement is [MOH.0011.0021.0001]. You'll see there is a screen just next to you. You're also very welcome to use your hard copy of it if that would be more convenient to you, but could I take you first to paragraph 5 of your statement. You tell us you are the

professional lead for doctors across the LHD responsible for ensuring the system and processes for recruitment of the medical workforce within your LHD. That's divided into two different categories, there is the AMRs, or the AMR process. Can I just ask you a little bit about that. Is that the process which is administered by HETI for the recruitment of junior medical officers?
A. HETI does prevocational PGY - post graduate year - 1 and 2. The AMR is for the remainder of the junior medical workforce.

Q. So there's the PGY1 and 2 recruitment pathway which is administered by HETI?
A. Which would classify as part of our annual medical recruitment.

Q. Separately to that, though, there is the AMR process that you're referring to in paragraph 5 of your statement?
A. Yes.

Q. And then in addition to that, there are other recruitment pathways for medical staff, perhaps typically more senior medical staff?
A. Senior medical staff, yes.

Q. Could I start just with the HETI administered process. Do you have a role in relation to that - that is, the PGY1, PGY2 recruitment process?
A. Yes.

Q. What's that role?
A. The role that I have is to ensure the numbers put forward by our facility are correct to allow that recruitment to happen.

Q. And the numbers, when you refer to the numbers put forward, that's informing HETI of the number of interns that you have capacity to accommodate within your LHD in any given cycle?
A. Yes.

Q. Are your hospitals part of particular networks that operate throughout the system in terms of the PGY1 and PGY2 training?
A. Yes.

Q. What are the networks that your hospitals are involved

in, if you are able to call them to mind; if not, feel free to tell us you can't?
A. Network 13 and network 15 are the two networks.

Q. Do those networks have - are they networked with larger metropolitan hospitals in other LHDs, or are there other metro-based hospitals all within Western Sydney LHD?
A. I would have to take on notice the actual sort of make-up of those networks, but yes, for example, the Children's Hospital is part of one of our networks.

Q. Maybe if we could move to the next recruitment process, the AMR process that you tell us about in paragraph 5. So that's recruiting junior medical officers who have typically completed PGY1, PGY2?
A. Yes.

Q. Could you explain to us how that process works in a practical sense, perhaps through the eyes of a PGY3 or plus candidate looking for employment within your LHD?
A. So the annual medical recruitment, it occurs at one time across the state, and that helps reduce competition from other districts recruiting early. So we all go at the one time. It's a process where you are able to apply for various positions within various districts. So it's not one application for multiple positions; it would be one application for one position.

Q. So insofar as your LHD participates in that process, at some point before the magic date, you will have identified a central administrator of some sort, exactly which positions you have available to be filled for the coming year?
A. Exactly right.

Q. Who does that central administration? Is there a body within the ministry that does that or is it just that by agreement between the LHDs everyone jumps at the same moment?
A. Can you repeat the question, sorry?

Q. In terms of that recruitment process under this AMR scheme, is there a central ministry body that administers it and does the recruitment once you've identified the positions you have to fill or is it something which is still managed at an LHD; level.
A. At an LHD level.

Q. So is it the case that the timing of it is really essentially an agreement between all of the LHDs to avoid competition that you'll all do it at the same time?
A. Yes.

Q. How do you go about advertising the positions? How would a candidate discover that there's a registrar's position in a particular field available at Westmead Hospital?
A. So there is a schedule of dates for various positions available throughout the state, and then through the eRecruit, you can search a job number description and then different options would be available for you to apply for.

Q. But having applied for that job, the actual recruitment, the considering applications, interviewing candidates and the like, is all done locally within the LHD?
A. Yes.

Q. Does that include the recruitment of registrars who are entering into training programs, vocational training programs?
A. Yes.

Q. And also I think you've referred at the end of paragraph 5 to what you've described as the unaccredited junior medical officer roles. Would it be correct for us to assume that the distinction between, say, a trainee, a registrar trainee on a program, on the one hand, and the unaccredited junior medical officer is the unaccredited junior medical officer is PGY3 plus but not, at that stage, part of an accredited training program? That was a very long-winded question.
A. That was a --

Q. Maybe I will ask it in a shorter way and you can actually give me the answer that I'm trying to come up with myself. What is an unaccredited junior medical officer role?
A. So an unaccredited junior medical officer role is one that is not in an accredited training program.

Q. So is part of the AMR process recruiting junior medical officers who are entering into and have obtained or hope to obtain an accredited vocational training place and

also recruiting junior medical officers to form part of the medical workforce but not on an accredited training pathway?
A. Yes.

Q. So in relation to the accredited training pathway places, how are decisions made within the LHD about who gets recruited to a particular training position - that is to say, an accredited training position? If a candidate, say, wanted to become a radiologist and was applying for a radiology training position that was available within your LHD, how would that decision be made?
A. Through a competitive recruitment process.

Q. Who's the decision-maker in respect of those positions? And I'm asking this not with respect to radiologists at the moment but more generally. Is it the LHD or is it the college or some combination thereof?
A. A combination.

Q. Does it vary from college to college in terms of the way those decisions are made?
A. I would say yes.

Q. In what way?
A. So not - so there are some centralised panels that help with recruitment, and then there are some matchings that occur with some colleges. Other colleges may just have - you can recruit to your own number without going through a centralised sort of recruitment process.

Q. So is that to say that a particular college might have a funded registrar position within your LHD and that college, under some arrangements, has a capacity to choose its own candidate and parachute them into the position?
A. No. So the recruitment happens through a panel in accordance with policy.

Q. Yes.
A. People on that panel may be members of - would be members of the college, but the college itself doesn't actually sit on the panel to make that decision.

Q. But at least in the case of some colleges, there needs to be a matching up between the decision made by the college on the one hand as to who to approve for a training position and the decision on the LHD's hand as to who it

wants to employ in that position?
A. So in terms of - so yes. In terms of, say, surgical training where they limit numbers, that is a different process to, say, physician training, where there is - the capacity is not necessarily set by the college.

Q. I might come back to that in a moment in terms of the setting of capacity. If you could go over to paragraph 6, you tell us that since commencing in your role you have extended the scope of the role to provide increased oversight of the medical college accreditation. What are the changes that you've made to the way in which the role operates that you're referring to in paragraph 6, in a practical sense?
A. Yes. So the main difference that we have implemented is that we now have a clearer escalation point up to the district executive level. So there is clearer communication between departments, facility executive and district executive and also to the colleges around the accreditation process.

Q. So what is it that you are hoping will be better communicated through those pathways going forward?
A. What we have seen is there's better communication of concerns from the department and the facility executive up to the district executive, and also concerns of the colleges that they feel may not have perhaps been understood as well at the facility or departmental level as well. So it's a much more partnership approach.

Q. So what sort of concerns might be being raised at the department level? Is it concerns about decision-making around how the department is resourced or what are the sorts of concerns that you are potentially seeing being escalated through that pathway?
A. The main themes that we see are workload; concerns around supervision; access to training; and then also there is always the avenue for feedback around complaints or grievance management as well.

Q. When you refer to complaints and grievance management, is that a reference to complaints about individuals within departments - that is, disciplinary complaints about the way people might be conducting themselves?
A. Yes.

Q. So that's one side of it. The other side, I think,

you referred to workload. What are the workload issues that get filtered up to you through this process?
A. The ability - because the colleges would be around access to training and maintaining their standards, so a feedback theme will be about the availability of trainees to access scheduled education time.

Q. That's because of the workload that they are having to also meet whilst doing their jobs?
A. Yes.

Q. Is that a common issue that has arisen or is it --
A. I think it is an issue that has arisen. I think service versus training are always two difficult things to juggle sometimes.

Q. In your role and from the LHD's perspective, when those concerns about workload and its impact on access to training are raised, what's the typical response? What process do you follow when dealing with those sorts of concerns when raised?
A. So there are several things that we would routinely do. First of all would be to go and have conversations with the clinicians on the ground, the heads of department, the directors of training, to see if any - and the facility executive - to see what themes and feedback have been fed back before; and then we would also review rosters, overtime, those sorts of things.

Q. Do you find that, through that process of reviewing rosters and overtime, you are able to deal with the workload challenges that are fed up to you, or is it something that realistically requires more people to be employed to do the job in those particular departments?
A. I think it's complicated.

Q. In what way?
A. That it's not always as easy as just putting extra bodies on the ground because the workload is sometimes an evolving piece of work; it's sometimes around setting expectations and reminding people of expectations around training and being an accredited site to allow trainees and also supervisors to ensure that training happens.

Q. Who is it - when you refer to the need to remind people of the expectations around training, who typically needs to be reminded? Is it the trainees or the trainers?

A. I'd say both.

Q. In terms of the allocation of an accredited training position within the LHD, is our understanding correct that there's essentially two steps that are required. The first is the LHD needs to fund salary of a registrar's position within a particular department or unit within the hospital; is that an important first step?
A. Yes, yes.

Q. And then the second step is that training position needs to be - or that department needs to have been accredited to train that person by the relevant college?
A. Yes.

Q. And colleges might identify the number of training positions which they think a department, having regard to its composition, is able to accommodate, if all other accreditation requirements are able to be met?
A. Yes.

Q. Could I ask you to go to paragraph 18 of your statement. You see in the first sentence you refer to the LHD currently being funded for around 1,000 FTE of JMOs??
A. Yes.

Q. When you refer to "JMOs" there, does that include interns and PGY2s?
A. Yes.

Q. So the 1,000 is everyone from intern all the way up to CMO?
A. Provisional fellow.

Q. So where does CMO fit within this?
A. They would be seen as in this recruitment as well.

Q. So the list of JMOs there would include CMOs?
A. Yes.

Q. Is that number, the 1,000 that's identified there, based on an assessment of the needs in terms of the workforce, or is it just that that happens to be the amount of money that's available and it's the way it's been carved out?
A. I've only been in the role two years so I can't comment on the workforce planning to this date.

Q. In terms of what the planning might be happening at the moment with a view to the future, do you have a view as to whether 1,000 FTE worth of JMOs is adequate to meet the needs of the community who access your facilities in Western Sydney LHD?
A. I think that's a complicated question to answer.

Q. Yes.
A. If we are fully recruited, my assumption would still be that there would be a need for unrostered overtime and overtime as well.

Q. So let's break that down into a couple of components. When you talk about being fully recruited, is that fully recruited to the JMO positions or what?
A. Yes, JMO.

Q. The JMO positions. In terms of those JMO positions, what's the current level of recruitment - that is to say, of the roughly 1,000 that you're funded for, in very much ballpark terms, what proportion of that do you think is currently sitting vacant and waiting to be filled by a happy JMO?
A. I want to say I'd have to take that on notice. I've been out of my portfolio for five weeks and it's around this time that we do tend to see a natural attrition of some of our JMO workforce for various reasons. But we would probably hold, say, a ballpark figure of maybe 30 FTE or 40 FTE vacant, but that I'd have to take on notice and clarify.

Q. It varies from time to time, but 30 to 40, as a very rough ballpark, is roughly the number that you're looking to fill. Is that because you've got 30 to 40 people leaving or is it that of the 1,000 that are funded there is perpetually that ballpark of 30 to 40 which just aren't there?
A. No. It changes over time, I think.

Q. In what way?
A. That there is always movement within a JMO workforce. People choose to reduce their fraction, you know, request to go part time for various reasons. They can include exam, study, personal reasons, maternity leave. So they will leave vacancies. Some terms actually align themselves more with the financial year for various reasons, and so we

would - 12 months into a temporary position, their time would be up so we'd have that vacancy to then recruit to mid-year. And then there are some harder to fill vacancies that we may hold from the beginning of the clinical year that we were unsuccessful in being fully recruited.

Q. A moment ago you said if fully recruited, it was your view that there would still need to be reliance on overtime and any other forms of premium labour; is that - could you just expand on that a little bit? Assume you've got your 1,000 FTE worth of JMOs and they are all - they've filled the positions that you have wanted them to fill. What's going to be needed, in your view, to deliver care to the community who access your facilities?
A. I can't give you a number of what we need in terms of JMOs. It depends on the other services that wrap around the JMOs as well and also the models of care that we implement with the JMOs. I feel the reason for overtime, though, includes things such as emergencies that happen at shift changeover; ward rounds that may occur late for various reasons; theatres that overrun. So I think there will always be a need for overtime in this sort of environment.

Q. Is there a process of workforce planning that occurs within your LHD that you're aware of?
A. Yes.

Q. What is that process, or what's your involvement in that process would be a better question for you to answer?
A. Yes. So I primarily deal with medical workforce, we - because annual medical recruitment is every year, we do review our numbers every year. We are constrained by our budget and what that looks like. However, when we do look to plan for what our community needs, that's a consultation period that includes clinicians on the front line, executives, we have a team of planners, and then that would be appropriately sort of briefed up as to, "This is what we feel our workforce needs for this reason", and then, depending if we have the resources to fill that, that is what would happen.

Q. When you say depending on whether you have the resources to fulfil that, are there two components to that, firstly, funding for the positions?
A. Yes, unless, within our budget, if we moved positions around or changed where the budget goes, that's - unless we

had an enhancement, that would be --

Q. Where you refer to available resources, the first important available resources is funding to actually pay the salary of people?
A. Yes.

Q. The second important resource is a warm-blooded person who's willing to accept that salary and do the job?
A. Yes.

Q. Starting with the first, in terms of the funding, is that - well, of the two, which do you think is the limiting factor from the point of view of your being able to meet the clinical needs of the community?
A. We get our budget every year and that's what we then plan our workforce on.

Q. If I could take you down to paragraph 19(c), you refer to the fact that consistent with something you told us a moment ago, your workforce data shows that there are many areas routinely rostering overtime and there's a high amount of accrued leave for JMO staff. Is that an indication that more JMO staff are required within the LHD, not asking for a precise number, but more JMO staff are required within the LHD to meet the clinical needs of the community?
A. It could be an indicator of that. It also can be an indicator of workload, model of care, vacancy rate held by that department at that stage. And the other staffing within the department can also have a direct impact on the amount of workload a junior doctor in training can do.

Q. So to that point, for example, the unaccrued leave and the overtime, may it be the case that although there is an ample number of, hypothetically, JMOs within the wider system, within your LHD, if they're not in a particular department at a time when that department has particular needs, then there will be a need to have recourse to overtime and it might be difficult to take leave?
A. Yes.

Q. Can I take you up to paragraph 19(a) --

THE COMMISSIONER: Can I just ask a clarifying question?

MR MUSTON: Certainly.

THE CHIEF COMMISSIONER: Q. When Mr Muston was asking you - he was talking about the two components being the funding to pay the salaries of people and then having what he described as a warm-blooded person who is willing to accept the salary, Mr Muston asked:

> *Starting with the first, in terms of the funding, is that - well, of the two, which do you think is the limiting factor from the point of view of your being able to meet the clinical needs of the community?*

You said:

> *We get our budget every year and that's what we then plan our workforce on.*

Is there a prior step, though, to either going to - either the LHD going to the ministry, or however it's done, saying, "This is what the demand will be and therefore you're going to have to fund this amount of workforce", or is it literally, as you said it, "We get the budget and we'll have to work out how many people we can employ based that"?
A. Because the budget sort of - sorry, I obviously didn't make myself very clear. The budget does not change a lot from year to year, and so, therefore, we can sort of predict - our JMO numbers remain quite stable unless we do have an enhancement for a particular service. There is always a conversation that occurs with the ministry around what our service needs are and sort of the priorities of the district and then what would be advocated from the district through to the ministry in terms of other funding that would help our communities in terms of what we need.

THE COMMISSIONER: Thank you.

MR MUSTON: Q. Can I just ask a follow-up question from that. Does that advocacy, to your observation, at least whilst you have been in your current role, tend to result in more funding being provided or is it listened to politely and then you get the budget which, to adopt your phrase, doesn't change much from year to year?
A. So I would say the current financial climate this year probably is not the same as what it was four years ago and COVID changed things. I think with COVID, the budget was

there to provide the care that was needed to the community.

Q. Post COVID, so the current climate, how do you assess that from the financial perspective on that same measure?
A. In terms of what we have received as the budget?

Q. Yes.
A. I've only seen some aspects of our budget for the district, so I can't really comment on all the nuances, what we have received in terms of growth versus what we received from last year.

THE COMMISSIONER: Q. No, but you said - part of your answer was:

> *So I would say the current financial climate this year probably is not the same as what it was four years ago ...*

What did that mean?
A. It probably would not have as much growth in it as what it was before.

MR MUSTON: Q. Could I ask you to go up to paragraph 19(a). So here we're talking about, as I would understand your statement, trainees in accredited training positions. Have I understood that correctly?
A. 19(a)?

Q. 19(a).
A. That is accredited/unaccredited trainees.

Q. Can I ask two questions about that? The first is, to the extent you are talking about accredited and unaccredited, insofar as the unaccredited are concerned, the limitations on specialists needed to supervise or the ratios are less important; is that correct? Or have I misunderstood that?
A. All doctors in training need appropriate supervision. Some colleges have, I would say, quite firm guidelines around what they feel is an appropriate level to be trained as an accredited position.

Q. So as I understand what you're saying, you might have a college that says, "Having regard to the number of staff specialists or VMOs in a particular sub-specialty that you have in that department, we will accredit you to have up to

two accredited training positions, because the ratios only support two people being trained having regard to the number of trainers"?
A. Mmm-hmm.

Q. Just say "yes" out loud, so --
A. Sorry, yes.

Q. That's okay.
A. Yes, that is correct.

Q. But in terms of then supplementing the workforce with unaccredited JMOs and career medical officers, that same college issue around supervision is less of an issue, is that correct?
A. I wouldn't say less of an issue. That's a decision that has to be made by the clinicians and also the facility executive around what we feel the supervision is needed to ensure those unaccredited trainees still get good supervision and also access to education as well.

Q. So I probably wasn't as clear as I should have been. Important consideration from a facility point of view in terms of making sure that junior medical officers and career medical officers are working sufficiently with specialists to make sure the care they are delivering is appropriate?
A. Mmm, yes.

Q. But from the college's point of view, the college doesn't step in and impose limitations on the number of CMOs or unaccredited JMOs --
A. That is correct.

Q. -- that you are able to employ?
A. They only focus on their accredited trainees.

Q. So when you tell us in paragraph 19(a) about both the funding limitations, or the budget limitations in terms of the number of trainees unaccredited and CMOs that you're able to employ on the one hand, and then on the other hand limitations imposed by colleges, what is the limiting factor in terms of the number of people who you're able to employ in a realistic sense? Is it the colleges saying you can't employ more people or is it the budget dictating that you can't employ more people?
A. In terms of all the colleges' supervision ratios, I'd

have to take that on notice to nuance down. Of course there are some colleges I've dealt with more closely, such as radiology, that have very specific parameters around what they feel is appropriate for senior consultants to trainees. But not all colleges have that level of specificity. So I would say the budget is probably - goes hand in hand with our numbers versus we can't supervise them. But it is an important aspect when you have doctors in training, or even junior doctors, that they are supervised appropriately, so that is something that - if we cannot supervise them, we would not be able to have them.

Q. Would it be fair to say it varies from college to college or specialty to specialty?
A. (Witness nods).

Q. But if there was more funding available to fund registrar positions within at least some specialties, do you have a view that the LHD would be capable of training more specialists and wouldn't find that it was encountering resistance from the colleges to that course?
A. I think, depending what college you were speaking to, the ones that didn't have capacity to train or caps on their numbers, they would not - as long as we met the requirements, they would not have a problem with us increasing our numbers.

Q. So for some specialties you don't anticipate there'd be any issues from the college's perspective with you creating more training positions; other colleges, there might be an issue?
A. Correct.

Q. You mentioned earlier in your evidence that there are particular caps on training numbers imposed by the surgeons. Could you expand on that a little bit --
A. They have a --

Q. -- as to your understanding of it?
A. Yes. No they have a more competitive requirement into their training program, is my understanding, and so they limit the number of trainees that will be put through their college program.

Q. When you say "competitive", on what basis are they limiting the number of people who are allowed in, at least insofar as you are aware?

A. I can't speak to why the college chooses so many - they set their number at what number.

Q. But is it at least your view from your perspective that those numbers are not being capped by reference to, say, training ratios and the sorts of issues which might be relied on by other colleges to refuse to accredit a position within --
A. I don't think that's the case.

Q. It's not --
A. I don't think that's the case. I really can't speak to why they choose. There are, like, 20 ENT surgeons training positions, for example. I have no insight into why that number is their number.

MR MUSTON: Commissioner, did you have a question that you wanted to ask?

THE COMMISSIONER: Yes.

Q. What I was wondering was whether, if the colleges were told there was additional funding for training, would that number go up or you don't know the answer to that?
A. I don't - I don't know the answer to that because we have - in a lot of our departments such as surgery, we would have accredited and unaccredited trainees.

Q. I see. I see what you mean, yes.
A. So we do have more numbers than what are trainees. Well, they are often side by side.

MR MUSTON: Q. Could I ask you to track down to paragraph 19(d), just a couple of questions about that. You talk about some of the challenges in recruiting into specialty areas. I assume that we're still referring there to trainees' positions within specialty areas?
A. Yes.

Q. You tell us that in some specialties there are not trainees to join the training program. Do we take it from that that there are training positions both funded by the LHD and accredited by particular colleges which you are not able to employ people to take up?
A. Yes.

Q. You give the example there of intensive care. What

are the factors which are driving that, do you think? Not so much the intensive care example but what are the factors which are leading to training positions in some areas of specialty being available in the sense that they're funded by the LHD and accredited by the college, but not filled?
A. So I think that, again, it's a complicated answer. I think part of it is there is a - I think there is a change in expectation of our doctors in training about what lifestyle and what career they want to have versus previously.

Q. What is that change in a nuts and bolts sense? Is it money or is it working hours or what are the drivers in that space?
A. I think it's both of those things. I think it's remuneration, I think it's flexibility, I think it's access to training, I think it's what the employment opportunities are at the end of their training. A lot of these doctors are training at a time of their lives where they are trying to buy a house, have family, have children, so there are multiple reasons, I think, that things would change for doctors in training, and I think what is seen on the back of COVID, where people's priorities have changed and what they want to do has changed. So I think there is always - in my understanding and my reflection of medicine over the years, there's always specialties that become popular and then don't become popular, but I think there are reasons probably bigger than that at the moment for why people are changing the way they want to work.

Q. That's a more general observation about why a training position in some areas of specialisation might be hard to fill. At an LHD local level, you tell us at the end of paragraph 19(d) that the LHD rates low on preferencing in centralised recruitment processes. Could you explain what you're referring to there and how that impacts on recruitment?
A. Yes. So for - this is for our PGY1 and 2, when it's a preference match system, Blacktown Mount Druitt, for us is often ranked the last choice of all the sites for those recruitments.

Q. Does that mean that positions at Blacktown remain unfilled or does it mean that people, whilst it might be their last choice, those who reach the point in the process where they're given their last choice, go to work at Blacktown?

A. This year we ended the recruitment nearly fully recruited, for Blacktown Mount Druitt. So this year was a good recruitment year for us.

Q. And in terms of the candidates or the applicants who end up going out, say, to Blacktown Mount Druitt, which might be ranked lower on their preferences, having regard to the categories of applicants, is there a particular category of applicant that ends up going to that facility more often than others, say those who are, perhaps, international medical graduates, for example, or is it --
A. So we would have a - out of the three main facilities, we'd have a larger proportion of international medical graduates at Blacktown Mount Druitt Hospital.

Q. But they are still recruited through - for PGY1 and 2 through the HETI process?
A. Oh, sorry, for the HETI process. No, the HETI process is the - they do have overseas, but this is the - that's the majority of the universities that come through, through the matching program. But in terms of our other recruitment, sorry, we do have a large number of doctors who are on visas or who are international medical graduates.

Q. Does that create any issues in terms of the way that hospital operates or are there any particular challenges associated with needing to on-board a larger proportion of international medical graduates to deliver care, no doubt fine care, in those facilities?
A. So there are challenges around on-boarding international medical graduates, because they need to go through various other processes, and that often takes time. So their start dates are often delayed. They are often overseas when they apply, so relocating them over, going through their various AHPRA registrations, those sorts of things, take longer, so they tend not to start at the same time as our other medical candidates.

There are differences, depending where you trained - so IMGs is any international medical graduate, they could be Canadian, UK, Indian. There is also a period, I think - if you have not trained in our systems, there are nuances and cultural difficulties even within facilities versus within Australia to other countries, so that sort of - having that understanding and getting them work ready does take extra time, I would say.

Q. It takes extra time. Does it also take extra money, in terms of a drain on the LHD's budget?
A. While you are waiting for delayed starts, yes, because then that would be either increasing overtime, unrostered overtime, or the short-term use of locums. So yes, there is a cost to having IMGs while they're becoming on-boarded.

Q. And so to the extent that a facility within your LHD might have a slightly greater concentration of international medical graduates than other facilities within the wider New South Wales health system, that drain on the budget will similarly be more concentrated at those facilities; would that be a fair assumption?
A. Yes.

Q. Could I ask you to track down to paragraph 21. You're telling us about your attempt to retain JMOs. Just so I can understand conceptually what we're looking at there, is that the JMOs who have come in through PGY1, PGY2 and are working within one of your Western Sydney LHD facilities - is the retention an endeavour to try and keep them working within Western Sydney LHD facilities beyond that PGY1, PGY2 period?
A. Yes.

Q. What are some of the strategies that you've found are effective in terms of keeping workforce on beyond those first and second years of their post-graduation period?
A. I think there are several things that we have tried to do. One would be to ensure that we have a good culture within our facilities and in our district, and that culture is around also education and training, ensuring that we provide them with a good orientation, ensuring that they do have access to their leave, ensuring that we pay them for the work that they do. It's really foundational pieces that we are trying to make sure that we are sort of achieving.

We also try very hard to focus on our safe working hours as well, and one of the big ones for us is to ensure that people have those opportunities to access their training and other opportunities within our district.

Q. And in those efforts, have they borne fruit, in the sense of do you feel that you have been able to increase the ability of the workforce to access their leave and

training hours and those other things that sometimes are squeezed when work pressures are high?
A. Yes, so I would say that being in the role for two years, I think we are starting to see some traction in various areas of this.

Q. Other than attitudinal change, what else, if anything, is being done to try and free up that time to enable, for example, the training and education time, the TESL time, to be picked up?
A. From junior doctor perspective?

Q. From a junior doctor perspective in the first instance.
A. So part of that is ensuring that the first step is to be fully recruited, as the first step; to allow then to know the rosters we have that don't need to be filled. The second most important step is to have the senior medical doctors as well aware of the need for the junior doctors to attend training, and they also are instrumental in providing a lot of this training as well, so ensuring that our senior medical staff are themselves trained and available to do that training as well.

Q. Just while we're touching on the senior medical staff, you also have a role in relation to the recruitment, I think you told us earlier, of senior medical staff into the LHD's facilities?
A. Yes.

Q. You tell us a little bit about that at paragraph 42. Could you just talk us through what the senior medical and dental recruitment unit does and how it goes about seeking to recruit vacant positions for senior medical officers within the facilities?
A. Yes. So there are similarities with the junior medical recruitment to the senior medical recruitment. Again, approval is often - is sought to recruit to a vacancy and the reason for that vacancy. Once that approval is given, the position is then advertised electronically and then distributed locally. The candidate applies online. It then goes through a competitive recruitment process in line with policy and procedure, ensuring that our panels are in line with policy and procedure, the interview questions are correct, reference checks are done. Then that gets put through our MDAAC, which is the Medical Dental Appointments Advisory

Committee, where the process is reviewed. That then gets put forward to the chief executive to sign off the appointment.

Q. And there terms of appointments into senior positions, are there high levels of vacancies within the LHD or is it your sense that the funded positions that are available or broadly filled?
A. I think that we have pockets where we have higher numbers of vacancies than other areas.

Q. Are there any particular areas of specialisation which comprise those pockets, that you can draw to mind?
A. Yes. Anaesthetics and psychiatry would be our top two at the moment.

Q. Is that to say there are funded positions for anaesthetists and psychiatrists which are advertised and sought to be filled but you struggle to fill those positions?
A. Yes.

Q. Now, that brings us back to paragraph 12 of your statement, where you tell us about the two different models of retaining specialists, either as salaried staff specialists on the one hand or VMOs on the other. You indicate that VMOs are not the preferred model of service for the LHD, but nevertheless, they're providing an important service. What are the pros and cons of utilising VMOs as part of the workforce mix?
A. So VMOs primarily work in private practice, and they're contracted by us as an independent contractor. They do provide an important service. They tend to provide services where there is a discrete need, so either surgical lists, surgical procedures, discrete shifts or clinics. They also provide a lot of coverage to some of our on-call rosters as well to enable us to have access to senior clinicians after hours.

Q. They're all benefits to the system. Are there any detriments in terms of you referring to VMOs not being the preferred model of service? What do you lose by having a VMO instead of a staff specialist delivering specialist care within one of your facilities?
A. So you can pay for having a full-time VMO, which is expensive because of the hourly rate. The staff specialist model allows the clinicians to be on site, to be sort of

present during the days. The VMOs tend to come and go a bit more within what they are employed to do and contracted to do. So a staff specialist model is a model which allows there to be senior consultants on site and also be available for teaching and education and training and other administrative duties as well.

Q. In terms of the pockets of areas that you are finding hard to fill - for example, I think anaesthetics was one you referred to - is that because there's been a shift from a staff specialist position into - or staff specialist positions into VMO positions for, say, anaesthetists?
A. In terms of - can I clarify? In terms of you mean the workforce wanting to move towards a VMO model?

Q. Yes, in those particular pockets?
A. So for Blacktown, we have a predominant VMO model in any case, so that hasn't changed our model, and for Westmead, our model is staff specialists with some VMOs as well and that model hasn't changed either. I think it was just more of a - and it wasn't just to Western Sydney, the anaesthetic issue is broader than us, and again, that was, I think, people changing how they wanted to work and how often they wanted to work. So people were maybe looking for a more VMO type model.

Q. Is it reflective of perhaps better opportunities to earn larger levels of remuneration within the public system - within the private system, I should say?
A. I mean, definitely remuneration in the private system is more than in the public system.

Q. Does the VMO model have the advantage of enabling the public system to harness some of those specialists who might like to take the greater levels of remuneration that are available in the private system but, nevertheless, continue to deliver some at least small part of their service into the public system?
A. It can.

Q. When you say "it can"?
A. Well, it does, but I think in terms of running a service and training, it's not just about running a consultant-led model. I think we have responsibility for training, and so therefore, a full VMO service does not always work in that.

Q. In paragraph 13 you tell us a little bit about the social demographics of the Western Sydney LHD and some of the challenges that that presents. Could you expand on that a little bit? What is it about the social demographic of the Western Sydney LHD footprint that impacts upon the way in which care is delivered, or able to be delivered, and the cost of delivering that care within the LHD?.
A. I mean, Western Sydney is a growing population. I think we're one of the fastest growing populations in the state. We have an ageing population and also a very young population coming through, and we have a lot of the priority populations as well.

So we have a large migrant community; we also have a large Aboriginal community as well; and we have, over our district, some pockets within our district of extreme social disadvantage and very low health literacy. That impacts on several things for our clinicians. First of all, the amount of time per patient it takes to explain, whether that is through interpreters or through extended family and make sure there is an understanding. There is a lot of cultural differences as well around expectations. There is the difference in how the communities can actually access care and maybe pay for care outside, so there is probably a greater need for the public health system in this area.

THE COMMISSIONER: Q. I have probably been told this but are there higher levels of chronic disease in Western Sydney than other metropolitan areas?
A. I can't speak to other metropolitan areas but we do have high levels of chronic disease as well, but we have a lower - like, a lower life expectancy as well.

Q. And does that create - if the population was healthier - sorry, the fact of those levels of chronic disease and the other things you've mentioned like health literacy and socioeconomic disadvantage, does that create a burden on your emergency departments?
A. Yes.

Q. And equally, the chronic disease that exists, and it might go beyond this, that creates a burden that might be preventable with other things in place on the public hospitals generally?
A. Yes.

Q. And there's no criticism in this at all, please don't think there is, and this is probably a very vague and perhaps even naive question, but do you and your colleagues - I mean, you'll know in a previous year how many people were admitted into our public hospitals, how many people were entered into the EDs, and in relation to both, generally what either the injury was or the illness was that required acute care, and that will be some prediction for what you might face the following year. It may not be a great guide for 10 years' time because ageing populations and all sorts of things might get in the way. But given the strain the public hospitals are under and the EDs are under, do you and your colleagues have discussions about - along these lines: boy, given the demographics of our community, if we had, for example, broader, appropriate primary care and allied health care, don't worry about who has to pay for this, let's just say the Commonwealth should fund this, and it might require a whole lot of expertise to analyse this and it might also take a long-term trial, but if there was that broader and appropriate primary care that enabled some interventions into chronic disease and also maybe some preventions for periods of time, that that would take the strain off the public hospital system? Are those conversations had?
A. Those conversations are definitely happening. I mean, our clinicians are very passionate about our community and constantly feel that we need to sort of do better in this space and how can we do that with our - you know, with what we've got. So I think the primary care, the preventative medicine, the social determinants also look at social situations as well, which are really important, and the first 2,000 days of a child's life has direct impact on a whole heap of, you know, medical illnesses and conditions that occur later on, such as domestic violence, those sorts of things as well. So that is very much the topic of conversation in Western Sydney.

Q. And you tell me if I'm wrong, but is the topic of conversation generally along the lines of: boy, if there was an appropriate level of funding put into primary care in our community, particularly in relation to people that just either can't afford to go to a GP or don't go to a GP for literacy reasons or whatever, over a long period of time we might see some benefits in terms of what's happening in the public hospitals?
A. I think that is definitely part of the puzzle.

THE COMMISSIONER: You feel free to take that up. That's what I wanted to ask.

MR MUSTON: Q. You've told us a little bit in paragraph 12 about the fact that the awards seem to be based on a business-hours service whereas hospitals nowadays run 24 hours a day. Insofar as you are aware, what is done within your LHD to try and arrange employment of the medical workforce in that sort of 24-hour cycle, despite the fact that the awards, on their face, don't seem to contemplate that being a thing? How, at the moment at least, do you seek to get around that?
A. Junior or senior or both?

Q. Let's start with senior.
A. Yes, so I think the rostering very much relies on an on-call system to have that access to a senior opinion, and we ensure that our rosters have the appropriate level of coverage so that there is always someone - someone can ring for advice or, you know, if needed, they would attend the hospital if required.

Q. And is that, in your view at least, a realistic use of the on-call provision, or is it stretching the reasonable on-call provision within the award well beyond what might have been intended to cover?
A. Oh, I think - so I think things have changed and things have progressed, and how things were 20 years ago, and expectations then to now and what we can look at on the end of a phone or on a screen, things have changed in that regard.

Q. Do the challenges with the current awards present any particular challenges in terms of recruitment and retention within your LHD that you are aware of?
A. I think what we face in our LHD is probably reflective of the state, to be fair, because the award affects everyone.

Q. And what is that, insofar as at least in your LHD?
A. So the award - for us, there are - I think the main difference is the remuneration you can get in the private is so much higher than what you get in the public system.

Q. What about the junior medical officers? Are there issues there or is it - and if so, are they different?
A. The junior medical officers also are under the award

and under their rates, and they too - comparatively across the country, we may not be as competitive as other states.

Q. Do you have any sense, at least based on what you see within your LHD, that there is any sort of exodus of junior medical officers into locuming, for reasons associated with higher remuneration available in that field of endeavour??
A. I think there has been a change in the perception of locums, in terms of junior doctors seeing that as a viable option for them to, you know, pursue at various times of their career, and so people may leave to locum, or they want to locum on top of their other positions that they might hold.

Q. How does that work, locuming on top of the positions that they hold? From the perspective of a junior medical officer who is employed in a position within the LHD, how do they supplement that with locuming in a practical sense?
A. There are procedures around that and so they have to put forward that secondary employment is requested and then that has to be approved and negotiated between the facility and the junior doctor, in terms of what that looks like.

Q. Could I take you to paragraph 14 of your statement where you tell us that long-term future workforce planning is challenging. In terms of the way in which workforce planning could be improved --

THE COMMISSIONER: Q. Can I just ask, is that a reference to future workforce planning is challenging generally or are you referring specifically to Western Sydney LHD?
A. Both.

MR MUSTON: Q. What improvements do you think could be made to the workforce planning processes which currently exist insofar as you are aware of them? How do you think it could be done better?
A. In our district?

Q. Yes.
A. So in our district, I feel we have a process around looking at our needs and listening to our clinicians, working through models of care and what that would look like. So I think those processes are quite robust. I think part of the challenge for us in the district is it feels that there's a lot of planning that might need to

happen in a lot of areas medically, and this is - I think this is on the back of COVID and changing expectations and how people want to work, and the make-up of our workforce has changed over time, being a more - coming up to a more female predominant workforce, and that's not the only reason why people want to work part time, but there are changing expectations I think as well, so I think that makes it difficult.

Q. And so from a workforce planning point of view, is your point that the planning of future workforce needs and the way they might be met, needs to adapt to have a closer regard to the way in which people within that workforce are actually choosing to work these days?
A. Yes.

Q. And is it your view that that might not be happening at the moment quite to the extent that it could be?
A. I think it is happening. I think it is difficult to be agile sometimes in this regard.

Q. What do you think could be changed or improved to improve that agility?
A. For planning?

Q. For planning, workforce planning.
A. I think having - and I think work is being done in this space, but the bigger picture is always very important when you are looking at your own backyard as well, to see how you are sort of tracking with what the bigger picture is looking like, so that that work with what the ministry is doing around ensuring that workforce data is available, that we have appropriate workforce data that is available and that our data is sort of current is very helpful with that.

Q. So that's a change which you have seen while you have been in the role, is it, an increase in the level of workforce data made available to you for the purpose of fulfilling your role?
A. I would say yes.

Q. What sort of data do you receive which you find particularly useful in that context?
A. For me, I like to know the demographic and the changing demographic over time and the patterns of attrition that we would have. A lot of things can be

predicted. I think we mentioned before that there are often not a lot of surprises, but we always are. But understanding those sorts of changes that are occurring outside of that.

I think where the ministry has worked really well with the districts is around our forums in the executive director of medical services forums. That gives a lot of opportunity for people to share their data and share their experiences, and then things are often segued off into various projects, and then that helps you with your planning as well. So I think from that bigger picture, that is helpful.

Q. Could I ask you to turn forward to paragraph 16(b) quickly, where you tell us about the "Remuneration rates for non-specialist medical staff - short term/casual (locum) policy". You indicate that the figures or the rates said in that policy aren't reflective of the current market expectations. Do we take it from that that the policy and the rates set out in that policy are routinely ignored - that is to say, the system pays more than whatever rates might have been specified in that policy when it was created?
A. I wouldn't say "routinely ignored". I would say that there are challenges around adhering to the policy when you have significant or - vacancies in an area that need to be filled to ensure there is a safe clinical service.

Q. What does that mean? In a practical sense, from the point of view of someone who is trying to fill that position, what does that mean? They start with the policy, they see what it tells them in terms of the rates that they are strictly entitled, under the policy at least, to pay for the provision of the locum services, but the market says, "Well, we want more", what does person in the position trying to fill that role have to do at that point?
A. There should always be a discussion before locums are used around is there recruitment we need to do, is there overtime, rostering, those sorts of things that can actually occur to fill the shift? Then there would be a negotiation between the facility and the locum agency around the rate.

Q. That first step, the discussion, working out whether a locum is needed at all, are there any tools that the LHD is able to use to work that out beyond a whip-around and

asking everyone, "Would you be willing to do a bit of extra time here?" In terms of utilising as best as one can potential overtime resources and the like, are there tools or programs that the LHD uses to assist with that?
A. Outside of the rostering tools that they look at and they look at the - they look at their overtime usage already, so they do look at their data around that to ensure that safe working hours are adhered to, then it would be to work out what are the resources we have that could potentially cover that position or that role and what does that look like, before going on to a locum.

Q. Can I ask you to move forward and change topics slightly to paragraph 44 of your statement, where you tell us about the executive medical staff councils. You tell us in the second sentence there that the role of a medical staff council can be complex, as a small number of doctors are tasked with representing their peers, who have, unsurprisingly, a wide range of views. Just looking at that next sentence where you say that it's important that other engagement processes are also used, what are those other engagement processes which you think are an important part of the mix in terms of communicating and collaborating with the workforce around important decisions?
A. I think there are various forums that we would use in Western Sydney. The director of medical services at the facilities would have a heads of department regular meeting where important communications are given back and forth; it's not just a one-way pathway. The medical staff council is a really important forum to have, and we have that throughout our district. We have a clinical council as well. And then we also have other meetings where we ensure that clinicians are sort of engaged with, so there are views of not just facility executives but clinicians that are involved in those meetings or working groups and so on, so that their views and opinions are also heard at that as well.

Q. Where their views and opinions might differ from the executive in terms of, say, the way in which a particular department should be resourced - items in terms of personnel or in terms of equipment and the like - what's the process used within the LHD to try and work through some of those concerns in a way that, as best as possible, ensures that the clinician's views are listened to and acted upon to the extent that --
A. So outside of these other forums, we also have

clinical network directors and managers and they, for want of a better word, have streams that they are assigned to, so that's another avenue for heads of department to talk to them about their challenges, talk to them about what they feel their needs are.

The clinical network directors and their managers are also responsible for coming up with strategic priorities for their streams, and so they very much collaborate and communicate with the clinicians on the ground as well.

Q. Do you think, at least from the perspective of viewing it from your perspective, that's an effective mechanism for working through those challenges and concerns that members of the workforce might have about the way in which their particular departments are resourced, for example?
A. I think there are multiple avenues for people to be able to voice their concerns, including reaching out directly to myself or to other members of the executive as well.

MR MUSTON: I've got no further questions for this witness, Commissioner.

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

MR CHIU: No questions.

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

THE WITNESS: Thank you.

<THE WITNESS WITHDREW

THE COMMISSIONER: I guess it's lunch. We'll adjourn until 2 o'clock.

LUNCHEON ADJOURNMENT

THE COMMISSIONER: Yes, Mr Muston.

MR MUSTON: The next witness, Commissioner, is Professor Peter Hockey.

<PETER MOREY HOCKEY, sworn: [2.01pm]

<EXAMINATION BY MR MUSTON:

MR MUSTON: Q. Could you state your full name for the record, please.
A. Peter Morey Hockey.

Q. You are the executive director for quality and safety at Western Sydney LHD?
A. I am.

Q. That's a role you've held since May 2023?
A. Correct.

Q. You have prepared a statement dated 10 July 2024 to assist the Inquiry with its work?
A. I have.

Q. Have you got a copy of that statement with you?
A. I have.

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

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

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

THE COMMISSIONER: Yes.

MR MUSTON: Q. The statement is [MOH.0011.0013.0001] for the benefit of the operator and the transcript. Could I ask you, Professor, to take up your statement and just turn to paragraph 4. You tell us in that paragraph about the role you play in relation to clinical education within the LHD. Could I ask you, then, to jump forward to paragraph 8. One of the things that you are involved in in the context of education within the LHD is the clinical placement of the students who are undergraduate students at universities and other institutions --
A. Yes.

Q. -- training to be either doctors or nurses or allied health professionals?
A. Correct, yes.

Q. In terms of your role, do you deal with all three of those categories of clinical placement?
A. Yes, I do.

Q. That is medical --
A. Yes.

Q. -- allied health and nursing?
A. Yes.

Q. In terms of the process, you tell us in paragraph 8 that it is a manual process. What is the actual process by which clinical placement places are allocated to students at different universities feeding in to the Western Sydney LHD?
A. So because we place close on two and a half thousand students at any one time, it's a bit of a game of Tetris to try and work out where people are being placed. There's a very small unit that consists of two individuals who register placements on a system called ClinConnect, but due to the vagaries of different universities having slightly different curricula, slightly different lengths of placements that are required, there's a complex process of trying to ensure that students get the right length in the right specialty, and, frankly, this is done by manual process by these two highly skilled individuals in an office, who do this manually with bits of paper trying to work out where students are best placed to make the best use of all the learning opportunities that we have.

Q. We've heard from some educational institutions that, particularly in the allied health space, the availability of clinical placement opportunities is something of a limiting factor in terms of the number of graduates that they are able to produce through their institutions. How does Western Sydney LHD go about deciding which universities to allocate clinical placements to for, say, allied health trainees?
A. I mean, largely I believe it's historical about the relationships that have existed. We deal largely with the University of Sydney, Western Sydney University, Notre Dame - those are our three main ones but by no means exclusively. If we have capacity and we are approached by

universities, we're pretty agnostic about who we partner with, particularly with regards to allied health placements. Often the placements are one-to-one supervision so it's entirely dependent on a supervisor being present, being able to supervise those students. Those opportunities change because people go on leave or go off on sick leave or maternity leave. So it is a dynamic process, especially for allied health. There is almost a one-to-one relationship between a supervisor and a university about placements, which are then managed through our ClinConnect system.

Q. Does the LHD approach clinical placements, particularly for allied health, on the basis that it seeks to find within its various units and facilities as many placements as it has to offer?
A. You know, I think one of the challenges is we are passive recipients of universities having students wanting to come to us, and we do our best to accommodate the students, rather than trying to identify what our future workforce needs might be, and then to try and pull students in.

Q. So I'm interested to explore that with you a little bit more. Is that in terms of the way in which you as an LHD make decisions about the number of placements and the type of placements that you might offer, and do I gather from what you have said that there is not a particular strategic focus on driving placements in areas where you see the creation of a workforce pathway to fill current and future needs?
A. I think that would be an accurate description, yes.

Q. How do you think, from a systemic point of view within the LHD to start with, that system could perhaps be adjusted to better utilise the pipeline pathway opportunities that clinical placements potentially provide from a workforce perspective?
A. Yes, I mean, I guess one is talking here about workforce planning. I look at workforce planning in the immediate future and then the very long term, and of course different specialties require different lengths of training opportunities, and the longer the training takes, the more difficult it is to workforce plan, by which I really mean doctors take the longest to train and it's very difficult to predict what might be needed in 20 years' time. Nursing and allied health, generally shorter training periods. So

there is an opportunity to be more proactive in trying to identify workforce needs, and in my statement I give one example of radiation therapy, where there is a particular need.

There is growing requirement for radiation therapy for patients with cancer and a shortage of radiation therapists. So actively trying to work with universities to offer them placements has been a challenge, particularly when one university locally has stopped their degree course. But in fact, we've recently reached out to a university out of state who we were looking for radiation therapy placements and been able to offer them placements in New South Wales.

Q. Have you managed to observe in your time, in your role, any correlation between the offering of placements for students within your facilities and the ultimate uptake of permanent employment by those placement students within the same facilities, or is it too early to say?
A. I think generally, if you offer people a good experience, it's very likely they will look for employment in that area. So I know we spoke recently - the previous witness spoke about Blacktown Hospital and interestingly, giving a good experience to particularly international medical graduate doctors means that they stay in the facility, because they are having a good experience due to the good culture that they are working in. So certainly there are some early signs that when you give people a good experience in a facility, they tend to effectively be loyal and want to contribute to the organisation.

Q. In paragraph 8, you say there are significant efficiencies that can --

THE COMMISSIONER: Can I just ask one question of Professor Hockey.

Q. Just on paragraph 8, what should I understand by "automation".

MR MUSTON: That was my next question.

THE COMMISSIONER: Sorry about that.

THE WITNESS: Literally, this is a manual process with bits of paper, trying to tessellate the distribution of

placements. There has to be a much more efficient digital, artificial intelligence solution which is able to work out how you might more effectively place students.

THE COMMISSIONER: Q. You don't know quite what that is but it involves algorithms and some sort of computer power?
A. I would imagine there are far cleverer people than I am who could help you with that.

Q. Not necessarily but it obviously involves some form of - you are talking about something quite sophisticated here that --
A. Correct, yes.

Q. -- with the power that computers and artificial intelligence might bring, would lead to a great saving in time and work?
A. Indeed.

MR MUSTON: Q. Is there also potentially some scope for arrangements around clinical placements to be dealt with at a slightly more central level than it currently is?
A. I imagine there absolutely would be, yes, yes.

Q. I just have in mind the sort of centralised system which operates in the context of, say, intern recruitment and distribution across the system. There might be some scope for a similar system to operate whereby each LHD or facility identifies the precise number of clinical placements it has available and the precise places in which they are to be located, and some central system driven by a clever algorithm could probably --
A. I absolutely agree with that.

Q. -- fairly distribute those placements across the universities in a way which might avoid a Hunger Games type scenario --
A. Yes.

Q. -- arising as between the universities. Could I ask you just to go down to paragraph 10. When you are talking about training opportunities for doctors there, is that a reference to doctors in their PGY1 and PGY2 year?
A. It's really a reference to all doctors in training. We're moving into a situation in health care where clinicians need to be able to do far more than just look after a patient in front of them. I think the education

that clinicians need needs to be very different to the type of education I had, where one had to remember long lists of things. In fact, most of that information is now available on a phone in your pocket. So I think there are opportunities in education which technology have brought about, and if we're wanting clinicians - as I rightly believe we should have clinicians - involved in helping run and manage health services, we need to give clinicians in training some opportunities to see what those realities of running a health service are, in fact, like, rather than, in my case, coming to that late in life, having had a full and very comprehensive clinical training but actually had no idea about how a health system operated. So I think it's incumbent upon us to give trainees a broader education about systems and processes rather than simply the clinical world in which they are entering.

Q. You make the point that there are opportunities which are not being leveraged to provide training outside of the hospital setting. In terms of that training, let's move off doctors just for a moment, nurses and midwives, is that training in an undergraduate context or a postgraduate context?
A. I think it's in all contexts. I mean, historically we have trained people in buildings, usually called hospitals. Actually, we're now providing far more care in other settings - in patients' homes, in aged care facilities, remotely via telehealth. Actually, we need to train the workforce to work in those areas and that's true of every type of workforce.

Q. What do you see as some of the opportunities to provide training through the areas that are perhaps not quite so hospital-centric. How might that look?
A. Well, certainly in our organisation, hospital in the home or community services is our fastest growing service. Unless we train people and give them the skills to do that kind of care - and there is a different skill set required to manage patients remotely - we're not going to optimise the opportunity to do that. So I think we need to build in to the frameworks by which we're offering this kind of care - we need to build student placements into those, and that requires supervision, that requires thinking about the kind of curricula requirements that are required.

Q. So there's the development of that broader skill set. In the last sentence of paragraph 10, just at the top of

page 3 there, you also allude to the current training models perpetuating a belief in the New South Wales workforce that meaningful work must be done in a hospital. Why is it that the belief about where meaningful work is done is important, and maybe shifting that belief?
A. I think because historically we have put people into these facilities and by focusing their attention on hospital jobs, by definition almost, we're saying that other jobs are less important, and actually, we need to give people the opportunity to work in other areas. But we also need senior people to work in some of these areas so they become role models for working outside of hospital settings.

THE COMMISSIONER: Q. What would need to be involved then, for example, for training to be part of, say - whether it's hospital in the home or aged care facilities, there'd have to be some form of accreditation process for working in that and it being included as training?
A. Yes, absolutely. One would need exactly the same standard that one applies to hospital placements to be applied to out of hospital training facilities, yes.

MR MUSTON: Q. Moving to training in rural and regional locations, you touch on that in paragraph 11.
A. Mmm.

Q. Is that an issue which has an impact on Western Sydney LHD or is it more an observation more system-wide that you make based on the depth of experience you have across our and the English system?
A. It is more an observation. We do have some trainees - some of the trainees who come on rotation to Western Sydney do go out to Bathurst and Orange, for example, as part of their network rotations.

Q. I gather your view, though, is that a short period of time where you're sent out to do a 10-week rotation in a rural area doesn't do a huge amount to incentivise or encourage someone to potentially pursue a career in a rural or regional area?
A. I think providing some workforce to a rural area is helpful but actually, what one wants is buy-in from individuals, and to be perfectly honest, those short stints being sent out somewhere are not always welcome by people who, you know, have commitments, families, housing requirements in a metro area.

Q. You talk about the need for more incentives, and you give an example of some of the incentives that you saw work in the UK. Other than those that you have referred to in paragraph 11, do you have any views on what might usefully be done to incentivise a move into rural and regional practice by potentially younger doctors?
A. I think often what worries people as medicine becomes more complex, patients become often sicker, there are expectations from patients that are often difficult to be met - I think people feel quite vulnerable in more remote areas, and actually giving them access to more specialist care, which may only be available in a metro centre, so connecting people up and having those relationships whereby it's easy to feel supported from highly specialised care may be one of the issues that could mitigate that sense of isolation and vulnerability. And it builds up a collegiality. Health care is team sport and one really needs - you really need to be part of a much bigger community.

Q. I gather from some of the evidence that we've received to date that those sorts of networks and connections between rural and regional facilities and metro facilities sometimes exist in an ad hoc way, where, say, someone might have studied with a particular sub-specialist in a metropolitan university and has their mobile number, for example?
A. Mmm.

Q. But do you think there would be some utility in a slightly more structured networking of facilities so as to, in effect, make people working in a specialist area within a metro hospital required, as part of their job, to deliver some of that - to be the "phone a friend" or to deliver some sub-specialist care out in regional areas where the specialists --
A. I think absolutely, and you know, many of my colleagues do do that kind of thing, but actually, I think it should become more of the norm than just following individuals' interests, and there have been ad hoc arrangements that have developed over time and work very well where they are in existence, but I could absolutely see how one could partner a metro organisation with a more rural organisation and it just becomes part of the way of working, that there is an expectation that one serves two communities rather than one.

Q. In terms of vocational training, which we will come to in a minute, do you see that there are potentially opportunities through that sort of partnering to create more vocational training opportunities for specialists outside of the metro areas, through the ability to have some supervision delivered remotely?
A. Absolutely. And it's not only remote supervision. I think there are some highly skilled clinicians in some of the more rural areas. I think many of the vocational training placements probably need to be longer in the remote areas so that people feel embedded and part of a community and there needs to be a focus on giving high quality supervision.

Certainly my experience of talking to trainees in some of the more rural areas is they feel quite vulnerable because there isn't always the supervision, and if you give learners a good experience and good supervision, they have a great time, and it's good for patients at the end of the day, too.

Q. We've touched on workforce planning in the context of the clinical placements.

THE COMMISSIONER: Just before you go to that, can I ask a question about what was said in paragraph 11.

Q. The example you give in the UK of funding grants, what should I understand the exact nature of those grants to be?
A. So this is a particular problem around GP training placements, and it was a primary care focused initiative. You know, I always smile when I think about the UK talking about rural and remote, because it is hardly, distance-wise, very rural and remote, but there are areas where it's hard to get primary care, both GPs and trainees. So there was a centralised plan to give doctors 20,000 pounds to go and join a remote training scheme.

Q. So it's a direct grant to the trainee?
A. It was a direct grant to the trainee, and --

Q. To incentivise them to go and do some training in --
A. It worked very successfully in attracting people, with an unintended consequence of the fact that often the 20,000 pounds grant was just enough to help them put down a deposit on a house, in which case, they became embedded

in the community and actually we saw people ended up staying and working in that community, which wasn't the intended outcome but actually was a good outcome.

Q. Yes. I think you touched on it in the answer you just gave me, but - and tell me if you have a different opinion - would the challenges in Australia for that kind of program or incentive scheme be slightly greater given the greater distances and greater levels of remoteness, in New South Wales, for example?
A. I think it is absolutely a good point, but I think unless one tries some of these things and experiments, it's very hard to - we had no idea in the UK whether this would work and it was extremely successful.

THE COMMISSIONER: Thank you.

MR MUSTON: Q. I was taking you to issues of workforce planning, which we touched on in the context of the clinical placements. You tell us in paragraph 12 that you think there could be some improvements made to workforce planning in New South Wales. First question around that: what are the problems or challenges that you think might be better addressed through the improvements that you have in mind?
A. When I think of workforce planning, I'm trying to think of 10 to 20 years ahead. I would say it's impossible to do that at a local level. I think one needs to do this at a very minimum at state level. It's probably a national incentive to try and work out what workforce might one need in 15 or 20 years' time. And I'm not sure the market is the best way of doing workforce planning. I'm not sure anybody's cracked it, but I think trying to do it at scale, trying to work out where one sees the future of health care going and the numbers of training places determined centrally rather than by individual colleges is probably going to have a bigger impact on the whole system ultimately, rather than the slightly piecemeal approach we have at the moment.

Q. It probably gets me to my next point, but at least one of the improvements that you have in mind in paragraph 12 is a centralisation of decision-making around things like how many physicians should we be training for the next 10, 20-year horizon and of them, how many should be endocrinologists and how many should be rheumatologists, for example?

A. That's exactly the approach I have been used to. As I say, we don't always get it right, but it does prevent the skewing of the workforce. It also enables one to decide where training places are actually placed, so it deals with some of the equity issues of health care delivery.

Q. Does it potentially also provide some avenues, just building on something you told us earlier, to embed training opportunities in areas where there is, over that 5-, 10-, 15-year horizon, a perceived need for, say, a rheumatologist or an endocrinologist, you can say, "Well, we've got a perfectly ample opportunity to train rheumatologists in RPA but in fact we really need one, probably in five years, in Wagga, so let's try and find a way of delivering a training opportunity for a generation of trainees out there in the hope that one of them stays"?
A. Absolutely, yes.

Q. Could I ask you to go forward to paragraph 15 of your statement. You tell us in paragraph 14 about the benefits that you see of the relationship between Sydney University and Westmead, but then in 15 you tell us that you think that, as a system, the relationship between LHDs and universities is not always leveraged as well as it could be. What do you think could be changed systemically to improve the leverage of that relationship?
A. One of the examples I give there is what we've developed in Western Sydney is a cohort of conjoint appointments, of professorial appointments, which are co-funded by the LHD and the university. So it really embeds academics within the clinical service and brings with it opportunities for research, it attracts people. One specific example I can give in Western Sydney is we have a professor of infection prevention and control. It's a nursing position. It's highly unusual to have that specific intervention, but it has really raised the profile of communicable disease, our bio-containment centre in Western Sydney, and serves as an attractant for people to come and work in infection diseases in the locality. And again this is being driven by the LHD, not just by a university with an interest. It's really a common - it is common ground.

Q. Is it something that works best when it is dealt with at that LHD level or do you think that there's scope for some centralisation of the process to help smooth the

relationship between LHDs and universities?
A. Well, I'm sure centralisation can help but certainly in Western Sydney a lot of this has been down to longstanding relationships between individuals in the LHD and the university, who have been able to work together on creating these positions.

Q. The last question I want to ask you relates to what you tell us in paragraph 17. You tell us that you're not involved in the accreditation process insofar as a vocational training of specialists is concerned, but you presumably have the familiarity with how that process works in the facilities of Western Sydney LHD?
A. (Witness nods).

Q. What is different about the way that they do things in the UK, based on the experience you had over there?
A. So the system in the UK was almost identical to the system we've got in Australia. It was very much a college-led process. That got changed probably 15 or 20 years ago to take the accreditation role away from the colleges. The colleges' role became setting the curriculum, setting examinations, but really took away the opportunities for colleges to influence directly the workforce, and I guess because colleges are medical colleges, they take a medical lens; I think what one needs to think about with the workforce is the wider workforce. There are roles that allied health professionals, nursing, can play which may traditionally have been seen to be medical roles. So I think being able to take a much greater and non-professional oversight of accreditation has been a real positive, in the NHS, at least, whereby that role was removed from colleges and now is managed centrally by the education body that has education responsibilities for the entire workforce. Because if one needs to look at supervision of doctors, you need to look at supervision of nurses and allied health professions at the same time, so you need that wider oversight.

THE COMMISSIONER: Q. Can you tell us, what drove that reform process, do you know? Was it an inquiry that issued a report or --
A. I wish I knew the answer to that question because I've spoken to a number of senior people in the NHS to go, "How did they actually achieve that?" And nobody's been able to give me a satisfactory answer as to how that shift occurred.

Q. Do you know what the responses of the colleges were to this reform?
A. Yes. Colleges never like significant change or change in their function. In part, it was driven by the fact that there became a central education body, it was called Health Education England, and as part of their statutory function they became responsible for accreditation of training sites, and colleges just now play a much more defined and very distinct role in education.

Q. And does that mean that the colleges in the UK also don't play a role in the number of graduates that are sitting the examinations; it's done by the employer?
A. Not so much sitting the examinations; it's about the number of training places.

Q. Positions, yes, training places?
A. They are determined centrally through the workforce planning unit, no longer by colleges, yes.

THE COMMISSIONER: All right. We can no doubt find out some information about that.

MR MUSTON: Q. So the workforce training unit determines the number of training positions in a particular area of specialisation and how they might be distributed across the system in the NHS. Once those trainees have been through that training, they need to sit their exams?
A. (Witness nods).

Q. And for each of them who has reached the end of their training and wants to do that exam, they no doubt enrol with the college's exams --
A. Correct.

Q. -- and sit them, hoping to pass?
A. And then are eligible for a consultant position and, if workforce planning has been correct, there should be a consultant position available, because the last thing you want to do is train a whole load of cardiac surgeons to the point of consultancy and then realise there are no cardiac surgical jobs at consultant level, because that's not a good use of resources.

Q. Just on the topic of central education body, you tell us in paragraph 16 about the Health Education and Training

Institute, HETI, which seems to take the role of a central training or central education body within the NSW health system. What do you, from your perspective, understand the role of HETI to be within the system?
A. So HETI plays a very important role in the PGY1 and PGY2 years, because those doctors effectively don't have a college, so HETI is a de facto college, I guess, for them. HETI also run a number of other educational opportunities, some leadership opportunities, and they also oversee the mandatory training requirements across the state.

THE COMMISSIONER: Q. When you say "HETI is a de facto college", what should I understand the detail of that to mean?
A. They're really managing the recruitment placement of new doctors into the system.

MR MUSTON: Q. And in terms of ensuring that those PGY1 doctors go through the rotations that they need to go through in order to get to general registration, HETI has a role, albeit an administrative one, in making sure that the candidates cycle through?
A. Absolutely, and they oversee the committees that ensure the appropriate training is delivered to those doctors, yes.

Q. You tell us in paragraph 16 that, in your view, HETI doesn't leverage available opportunities as much as it could. You go on to give one example, but are you able to expand on the sorts of opportunities that you think HETI might be able to - or put more generally, a central education authority might be able to leverage within the New South Wales health system?
A. Yes. I mean, I guess if I reflect on my UK experience - and one of the reasons a centralised body had quite significant leverage is that half the salary of a doctor in training was paid centrally and half by the employing organisation. So it actually gave a very powerful lever to the central education organisation to ensure that appropriate educational opportunities were, in fact, being delivered, because if they weren't, the funding could be removed and effectively that post becomes non-viable because there isn't a funding in the employing organisation.

So it's a very different model. But it did give quite

a lot of power to a centralised body to be able to ensure standards and to determine where trainees went.

Coming back to HETI in particular, I guess it refers to my previous comment about giving people opportunities outside of their direct clinical world, and if we're going to train clinicians to be our leaders in the health system for the future, we should probably be exposing them earlier in their careers to some of the opportunities in the health systems that many of us, as we get more senior, fall into, if you like.

MR MUSTON: Thank you, Professor. I have no further questions for this witness.

THE COMMISSIONER: Do you have any questions, Mr Chiu?

MR CHIU: No questions.

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

THE WITNESS: Thank you very much.

<THE WITNESS WITHDREW

MR MUSTON: Commissioner, we have slightly changed the order of the witnesses to accommodate them, so it's going to be Jacqui Cross who is the next witness.

<JACQUI MARIE CROSS, affirmed: [2.38pm]

<EXAMINATION BY MR GLOVER:

MR GLOVER: Q. Ms Cross, would you tell us your full name, please?
A. My name is Jacqueline Marie Cross.

Q. You are the chief nursing and midwifery officer for NSW Health?
A. That's correct.

Q. You've been in that role since about June 2016; is that right?
A. Yes, it's my anniversary.

Q. To assist the Commission in its work you made

a statement on 8 July?
A. I did.

Q. It is [MOH.0011.0007.0001]. It's been brought up on the screen to your right but if you have a hard copy, feel free to use whichever is most convenient to you. Have you had a chance to read it again before giving your evidence today?
A. I have.

Q. Is it true and correct, to the best of your knowledge and belief?
A. It is. But there is just one comment I wanted to make.

Q. Yes.
A. I noticed on the list of witnesses, there is a notation of an AOM against my name. That isn't correct. I don't even know what it is.

THE COMMISSIONER: Well, you never know.

MR GLOVER: Q. Maybe someone knows something that you don't. That's fine. Thank you for raising that.
A. But I thought I'd better mention it.

THE COMMISSIONER: Q. That's not part of the official record so we won't worry about that.
A. Okay.

MR GLOVER: Q. You were awarded this year the public service medal; correct?
A. I was, yes.

THE COMMISSIONER: Q. There you go. So it should be, what, PSM, or something?
A. Yes, it's on there, too.

MR GLOVER: Q. Could I take you straight to paragraph 3, please. In describing your role, you tell us that your office is the professional link between the minister, the secretary, the senior executive team and the education sectors; do you see that?
A. Yes, I can.

Q. Can you just describe in practical terms what you mean by that?

A. What that means? It means I - well, as it says there, I provide advice regarding nursing and midwifery professional practice to the people outlined there. I also have linkages and relationships with the tertiary sector as well, so I liaise with the deans, heads of school and other professional bodies as well, to keep abreast of things that are occurring for nursing and midwifery.

Q. And in the advice-giving function, what matters would your office provide advice about?
A. It could provide advice around nursing practice, nursing education, models of care, yes, a broad spectrum of things really, yes.

Q. What about workforce planning and development?
A. Focus on supporting the workforce or the districts to support workforce, yes, and, you know, identifying any challenges with workforce as well as coming up with potential solutions to support the districts.

Q. We'll come back to some of those issues in due course. Can we go ahead to paragraph 7, please. There you tell us that your office works closely with the local health districts and specialty health networks and engages with nursing and midwives at all levels?
A. Mmm-hmm.

Q. In what ways does it do that?
A. Our main linkage is through the local health district, directors of nursing and midwifery. So we meet with them frequently, well, about once a month, and we also have formal and informal networks with them as well. I have a group of principal advisers working for me in various specialty areas, and they engage with nursing leaders, midwifery leaders across the state as well, through formal and informal forums.

Q. What are you engaging about? What are the things --
A. What are we engaging about?

Q. Yes.
A. We are engaging about pieces of work that we may be undertaking. We are talking about how we support the workforce, how we support the pipeline of new graduate nurses coming through, identifying any challenges. We scale pieces of work that may be occurring in the local health districts as well, so we'll identify initiatives

that they're undertaking and we may scale that to --

Q. When you say "support the workforce", what do you mean by that phrase?
A. Support the workforce? Can you --

Q. In that answer you said one of the issues that you might engage with the LHDs and the specialty health networks about is supporting the workforce. What do you mean by that?
A. So it may be, well, making them aware of scholarships that we provide. We have developed different programs, so we may be engaging with them or helping them to - helping - getting them to help us develop some of those initiatives. If I use an example, in the midwifery space, for example --

Q. Yes, please.
A. We've undertaken a big piece of work understanding the experiences of our midwifery students and the midwives that are supporting them. So that meant engaging with midwives right across the state, going into services, and I guess we supported midwives to go in and have conversations to understand what that experience was like for them and to identify any gaps.

What that led to was a midwifery mentoring program, which was developed with the midwives for the midwives, and has now been implemented in all of the local health districts.

Q. What are the benefits of a program like that?
A. Oh, the benefits of that are twofold - well, there are several benefits. I guess, as we said, when we first went in we were speaking with our midwives about what they saw, what some of the challenges were for them in supporting our midwifery students, and they saw a gap in their knowledge or their confidence, I think, in mentoring and supporting those students. So what it means, we get a good experience for the students, they feel welcome on the floor, they develop their skills and they want to come and work for us in New South Wales local health.

For the midwives, it is actually they're seeing that we're investing in their skills and really do want to support the midwives of the future, and they've seen that we've engaged with them and we're providing them the skills that they need.

Later on in my submission, you'll see that we've followed that up with some work to increase the number of bachelor of midwifery students coming through. We really needed to do that foundational work with regard to supporting our current workforce to support an increase in the number of those students as well.

Q. Why? Why did you have to do the, to use your phrase, "foundational work" to support new students coming through and in increasing numbers?
A. So they - well, first of all, so they can see the need to actually support those midwives in the right kind of way and as I said, helping them to develop the skills that they thought were lacking, where actually they did have some of those skills as well. So --

Q. Do you see that that work is having benefits for attracting greater numbers of students into the field?
A. It's attracting them but it's also retaining our current workforce as well, which is critically important, and we've had some really good feedback with regard to that.

Q. In paragraph 8 of your statement you tell us that your office has a number of other key partners?
A. That's right.

Q. One of them including the workforce planning and talent development branch.
A. Mmm-hmm.

Q. In what way does your office work with that branch?
A. We work day-to-day together. There's sort of a number of initiatives that - I think we support the outcomes, so the workforce plan for NSW Health, so there are a number of initiatives that we have that actually support them as well.

We also have visibility of, I guess, where workforce challenges may be as well, so we share information that we might have. We specifically, I suppose, link in with nursing and midwifery so we might have some awareness of things that they may not necessarily have or the contacts, so we actually share that information.

There have been a number of pieces of work that we

have worked on together, so there's some work that workforce planning and talent development led around success profiles, developing success profiles, and we did that work in our nursing workforce as well, so actually they sit together and complement each other. So there's a lot of shared pieces.

Q. To break that up a little bit, in that answer you mentioned that your office might have greater visibility of workforce challenges for nursing and midwifery?
A. Yes. Sorry, I might correct that. It's probably a different sort of lens on things, perhaps, yes.

Q. All right. Well, may bring a different perspective to those challenges --
A. Yes, yes.

Q. -- that the other branch might already have seen?
A. Yes.

Q. What do you perceive to be particular workforce challenges in the nursing and midwifery space at the moment?
A. I guess just to go back to that question a little in just a slightly different sort of --

Q. Yes.
A. Our office actually oversees the centralised recruitment of nurses and midwives, the graduate nurses and midwives across the state, so that, in itself, gives us some visibility of those numbers or where the positions are being put up across the state. So we have information because of the role that we actually undertake, so yes.

Q. With the benefit of that information and your wider knowledge of nursing and midwifery across NSW Health, are there any particular challenges you see in that workforce at the moment?
A. Yes. Well, as was put in my submission, midwifery is one area of greater challenge across the state, and as I've said in the submission, it's more broad than New South Wales, it's a national and international challenge. And within NSW Health, it varies in the different facilities as well. But it has been a very strong focus of our office to look for opportunities to increase that pipeline and to support the midwives that we currently have within our workforce.

Q. If we jump ahead to paragraph 32 of your statement - and I think this is a passage that you've just perhaps referenced --
A. Mmm-hmm.

Q. -- there you describe some national and international midwifery workforce challenges. What did you mean by that phrase?
A. What do I mean by that phrase? That there's shortages in that workforce, yes.

Q. And how long have those shortages been evident?
A. Oh, I couldn't be precise. Certainly in my role --

Q. Long term?
A. Yes, certainly in my role since I commenced, yes.

Q. Could I take you back to perhaps where we started in one of your first answers, in the training and education of nurses generally?
A. Mmm-hmm.

Q. And in paragraphs 14 through to 16 you tell us about the clinical placement process.
A. Mmm-hmm.

Q. Is there a particular challenge at the moment in facilitating clinical placements within NSW Health facilities?
A. I wouldn't - I don't actually think so. I think the data that we saw over - particularly over COVID, we actually were able to maintain and in some places increase clinical placements for nurses. We have a very strong - well, the local health districts have a very strong focus on that, yes.

Q. In paragraph 16, you describe the universities being in competition with one another. Do you see that?
A. Mmm-hmm.

Q. What's the issue that you're referring to there?
A. Well, look, competition means that really they are looking for the clinical placements, vying for the clinical placements for us across NSW Health, yes. That's what we mean by competition.

Q. So you're not suggesting by that paragraph that there's not enough places - not enough clinical placement spots to meet the demand for - of the universities within the system?
A. No, that wasn't the intent of that, yes.

Q. Jump ahead to paragraph 27, this is in the context of nurse practitioners.
A. Mmm-hmm.

Q. Just before going to the issue raised by paragraph 27, I take it from the content of your statement that you see great benefit to the system in the expansion of the role of nurse practitioners?
A. Yes, I certainly do.

Q. What is that benefit?
A. I think - well, it provides access to patients, you know, to the community as well, so it's another senior workforce within that whole health workforce, that 413. We've got some data I think from about three years earlier, there was sort of about 250. So we are seeing a growth in that workforce. So it's a part of the health care team, a highly skilled part of the nursing team, and I think that there's a lot of value add there.

Q. Is it perhaps one response to shortages in the medical workforce - doctors - in certain parts of the state?
A. Yes, absolutely.

Q. I'll come back to that in a moment. In paragraph 27 you tell us that recruitment to nurse practitioner positions in metro areas is relatively straightforward?
A. (Witness nods).

Q. And then you go on to tell us that in rural regions it's a little bit more complex.
A. (Witness nods).

Q. In paragraphs 28 and 29 you refer to the recommendations from the parliamentary inquiry?
A. Mmm-hmm, yes.

Q. What work has been done to progress the response to that recommendation that you've referred to in paragraph 29?
A. So you'll see in the submission that my office

actually developed a framework to support local health districts in our rural areas to look at models around what we're calling generalist roles. So when nurse practitioners were first introduced the idea of them was that they had that generalist sort of focus and they were ideally - they were sort of ideal for our rural/regional areas. Over the years we moved away from that and they became more and more specialised, so sort of working in our emergency departments, our intensive care units, special care neonatal intensive care units, and those. So really we just wanted to shift that back and provide local health districts with a way of looking at how they could utilise the nurse practitioners.

There was some funding that was available for 20 generalist nurse practitioners at that time. So it fulfilled the needs, and it's meant that the local health districts have been able to recruit to those positions.

Q. Just on the funding for 20 positions, you tell us about that in paragraph 30, which is just over the page?
A. Mmm-hmm.

Q. That's the 20 positions that you were just referring to?
A. Yes, that's right.

Q. Have they been taken up?
A. They have.

Q. And where were they located?
A. I haven't got the information in front of me but they are in the rural/regional areas but we could provide that for you.

Q. All right. And are there any other initiatives other than the 20 funded positions that you refer to in paragraph 30 to further expand the nurse practitioner workforce in rural and regional areas?
A. The work's happening in the - well, work really is happening at that site level, at the LHD level. So again, as supporting the districts to think about models of care and where they can introduce nurse practitioners, and as I pointed out, there's a transitional - we have a transitional nurse practitioner model which means that people can go into a training model, so that's something that works well for our rural/regional areas as well.

Q. Could I take you ahead to paragraph 40, please. In this section of the statement you refer to the recruitment and distribution of graduate nurses.
A. Yes.

Q. So they're newly qualified nurses at the start of their career?
A. That's right.

Q. And in paragraph 41, you set out a table. Just by way of clarification, are they the new graduates employed each year on a year-on-year basis?
A. Mmm, they are.

Q. And then there's a note to that table that says:

Definition of rural/regional data broadened from 2022.

A. That's right.

Q. In what way?
A. We changed our definition to mirror the definition that was used by workforce planning and talent development. So it includes other districts that we didn't formerly, previously, count.

Q. So what was - what districts that weren't formerly --
A. Central Coast, Illawarra and Nepean Blue Mountains are now included in that, yes.

Q. Thank you. In paragraph 40 you tell us your office - and you touched on this earlier - administers the central graduate recruitment program?
A. Mmm-hmm.

Q. Can you tell us in practical terms how it does that?
A. I can. We live it. We liaise really closely with the universities, but basically, people apply through a central portal, so the new graduates apply for positions in New South Wales through that process and they identify the areas in which they really would like to work and they sort of grade that, I guess, for a better term.

Q. Just pausing there, by "areas" do you mean locations --

A. Yes, locations.

Q. -- or areas of practice?
A. Locations. The districts put up the positions that they are able to recruit to then people are matched. If they don't get their first match, there's a process where they can go into the second match as well. The local health districts then undertake the recruitment. So they'll interview the candidates and they will select them accordingly.

Q. So as part of that process, the districts identify how many graduate nurses they would - positions they would wish to fill?
A. Yes.

Q. That goes into the system?
A. Yes.

Q. And the system does the matching process?
A. Yes. Then they will recruit them. Some - and then if people don't get the first round, they can be reallocated again as well.

Q. Is there any system-wide analysis about overall graduate nurse intake on a year-on-year basis?
A. System-wide in that we have data that tells us where people applied? Is that what you mean?

Q. Well, is it simply a matter left to the local health districts and specialty networks to identify the numbers that will be recruited year on year?
A. Mmm-hmm.

Q. Or is it part of a wider workforce planning task --
A. Oh, I see, sorry.

Q. -- undertaken by the ministry more generally?
A. I see what you mean. Yes, the districts look at the numbers that they will take, as you have said. They may do some local workforce planning. The workforce planning and talent development branch is just undertaking, beginning, some work around looking at the modelling for workforce for nurses and midwives which we are working alongside of them, but Richard Griffiths will be probably better placed to give you information about that.

Q. When you refer to modelling for the nursing workforce, what is that modelling that you're referring to?
A. Again, I think Mr Griffiths can probably give you a bit more detail but I guess that higher level predicting what we might require into the future.

Q. Does your office have input into that process?
A. We do, yes.

Q. In what way?
A. We're working just alongside them. Actually we'll be going into the districts with the team from workforce planning and talent development to work with the teams on the ground to identify or just to discuss the modelling and sort of, I guess, test it with them as well. So there's a process that's just started and it will be going on over some time to refine that.

Q. In paragraph 43 you tell us - and this is again in relation to graduate nurses - there's an overall strong supply?
A. Mmm, there is.

Q. And there are more applications than positions available. Is that the case across the state or is it directed to metropolitan areas?
A. The pool that come in, there are more than is required. But there is a maldistribution. So the challenges are in our rural/regional areas, like other workforces, so trying to attract new graduates to go into those areas, yes.

Q. Do we understand that it's part of the centralised process, there will be more applicants than total positions, but there might not always be a match between an applicant and a position --
A. That's exactly right.

Q. -- perhaps in the rural --
A. In some places we've actually recontacted some of the graduates who haven't got positions and asked if they would like to go and work in rural/regional areas and said, "There's an opportunity". Sometimes they might take that up, but a lot of times they don't.

Q. In paragraph 44 --

THE COMMISSIONER: Q. Just before you leave that paragraph, where you are telling us in 43 that there are more applications than positions available, is that by a significant number or a small number in percentage terms, do you know?
A. I don't know off the top of my head. I can take that on notice, yes.

Q. Do you know if there are significantly more applications than positions available or is it a close-cut thing? You can take that on notice too, if you want to.
A. Yes, yes.

Q. You have mentioned NSW Health has no visibility of the employment of nurses in private hospitals and aged care services.
A. Mmm-hmm.

Q. Would there be any advantage to NSW Health if it did know?
A. I think we really put that statement in there really I guess to say that out of the people who don't get - nurses who don't get positions, how many of them are employed in other sectors, that's why we put that in there.

THE COMMISSIONER: Okay.

MR GLOVER: Q. Paragraph 43.

THE COMMISSIONER: Paragraph 44 I thought were you going to.

MR GLOVER: I'm sorry, correct, 44.

Q. There you tell us that there is an undersupply of graduate midwives and we've touched on this earlier.
A. Yes.

Q. Again, I just wanted to clarify with you, you say there that the undersupply via the undergraduate pathway is linked, firstly, to the availability of training places which are determined by the LHDs --
A. Mmm-hmm.

Q. -- and geographic distribution of programs?
A. Yes.

Q. Dealing with the first of those two factors, the availability of training places determined by the LHDs, in what way does that limit the pathway for graduate midwives?
A. So I'll just take you back a bit because we have two pathways here in New South Wales. So we have a pathway for registered nurses who want to go on and become midwives and do a postgraduate diploma. That's our strongest supply. Then we also have the BMed, which are people who directly go on to do that. The universities tell us that they actually - well, we determine the number of clinical placements and by determining the number of clinical placements determine the number of applicants that they can actually accept into the programs. So if we increase clinical placements, we can increase the number of undergraduate midwives.

Q. And is there work being done to look to increase the number of --
A. Absolutely.

Q. -- placements?
A. Absolutely there is. Because we've seen in the data that that's the place where we can actually really focus in on and hopefully get some uplift in the numbers. So we have been working very closely with a number of the local health districts. We've gone in and spoken to the midwifery leaders and managers and talked about the - shown them the data around what the current workforce looks like and how they can actually - if they uplift, how that will support them into the future as well. So we have seen an uplift in the number of students.

Q. But at the moment, as it stands, the ability to increase the number of training places is a matter that sits within the remit of the LHDs?
A. Yes. The other thing, too, is we've engaged with the university partners as well. So they need notice if we're going to increase those numbers, so we've worked out how we're going to communicate that with them so that they can go back to their regulatory body and request more students. So we have to work in tandem with the university sector as well.

Q. In paragraph 45 --

THE COMMISSIONER: Again, just before you leave that.

MR GLOVER: Yes, I'm sorry.

THE COMMISSIONER: Q. What is the extent of the undersupply and, if you need to take that on notice, you can do that as well?
A. Yes. It varies across some of the districts, but we know - yes, so I can take that on notice and provide that data.

THE COMMISSIONER: Okay. Someone will follow that up.

THE WITNESS: Yes.

MR GLOVER: Q. In paragraph 45 you tell us about a targeted rural nursing and midwifery graduate social media campaign?
A. Yes.

Q. Is any work being done to assess the effectiveness of that campaign and others like it?
A. I think - well, really that would be through our social media comms team around, I guess, the number of times things are viewed. But we haven't formally had any evaluation of that from our office.

Q. In paragraph 46, and you have touched on some of these initiatives already in terms of incentives, grants available to students --
A. Yes, yes.

Q. -- the first one in 46(a), rural undergraduate scholarships, you tell us that scholarships of up to $5,000 are available to students from rural New South Wales, et cetera.
A. Mmm-hmm.

Q. And in the last sentence you tell us that scholarships are awarded based on the students' residential location and areas of workforce need?
A. Mmm-hmm.

Q. How are the areas of workforce need identified?
A. I'm just looking at that, because really it is around smaller sites, those sorts of areas within the rural/regional areas as well. I would probably have to take that on notice to give you more information.

Q. In an earlier answer you mentioned the NSW Health workforce plan.
A. Mmm-hmm.

Q. I just might take you to it briefly. It's [SCI.0001.0043.0001].

THE COMMISSIONER: What folder?

MR GLOVER: Exhibit A.048. It was tendered back in November.

THE COMMISSIONER: Okay, that's going to be back in my room. I'll just look on the screen. We're up to H on this table, we're going back to A. Actually, I thought I had that out here somewhere. You go on.

MR GLOVER: Q. Just in general terms --
A. Sure.

Q. -- I'll take you to some particular parts of it, but I'll start it this way, in an earlier answer you mentioned that part of your office's role is to assist in the implementation of this plan?
A. Mmm.

Q. Can you just describe, in general terms first, what role your office has in that process and in what particular areas does it have input?
A. Okay. So a lot of the strategies that we do link directly back to this plan. So if we look at the Aboriginal nursing and midwifery strategy, the work that I've been describing here around making sure that we've got a good pipeline of both nurses and midwives coming through. The other thing, as part of that, is making sure that we've got a workforce that's fit for purpose, I guess, for want of a better turn of phrase, and also that those graduates are work ready as well. So all the scholarships, the initiatives that we have in place are there to support the workforce supply, the retention, but also that they're able to function at a level that they should.

Q. I'll take you just to a few parts of the plan. We'll go to internal page 13, 0013. Do you see there 3.1:

> *Expanded scopes of practice for clinicians suit the local community need.*

Do you see that?
A. Yes.

Q. Then there are two horizon 1 activities in the dot points next to that?
A. Mmm-hmm.

Q. Is that one of the matters in which your office is involved?
A. That's certainly what I was describing with the nurse practitioners. Some other work that we've been involved in working with ACI is a body of work around supporting nurses in our emergency departments, being able to work to their optimal scope. So those are probably two examples where we're doing that.

Q. And I take it from that answer that there are benefits --
A. Absolutely.

Q. -- in nurses working to their top of scope?
A. Yes, yes.

Q. What do you see them to be?
A. Again I think I think it's access to care, that we're using the workforce in an efficient way, that, you know, we're mindful of the resourcing. Registered nurses are highly educated, so we need to support them to work to their full ability.

Q. Does it assist with retention of those mid and later career nurses as well?
A. Absolutely does. And also with our midwives as well, and - so if I go back to our submission, you'll see the approach that we're taking in pathways in practice, and part of the thinking around that is we want to support our nurses and midwives to be able to work to their optimal scope. So we're providing workplace learning opportunities so that they can actually be engaged in that.

The rural pathways in practice was an initiative that came out of one of the other - the Western NSW LHD, and that's now been providing sort of education around fundamental assessment in our rural sites, but we've expanded that now so nurses are now able to suture, can put backslabs on and those kinds of things, we've worked with

HETI to do that. So what we're doing is sending a message that nurses can be involved in those - for their skills. But also we've linked it to our scholarship opportunities as well. So what we're promoting is learning, lifelong learning and opportunity through their careers.

Q. Is that directed to, in an earlier answer you said producing a workforce that's fit for purpose?
A. Yes.

Q. Those type of initiatives go to that aim?
A. Yes, absolutely.

THE COMMISSIONER: Either one of you can answer this, because I don't have the document, MOH - Ministry of Health - what's WPTD?

THE WITNESS: It's the workforce planning and talent development.

MR GLOVER: Workforce planning and talent development branch. Have I got that right?

THE COMMISSIONER: Mr Chiu is nodding so I take that as affirmative. What is "SIA"? You don't have to answer that. I'm just going through these acronyms.

MR GLOVER: Mr Muston rightly reminds me that at page 19 of this document, which you don't have, but it will be on the transcript, that tells us that it is the system information and analytics branch.

THE COMMISSIONER: Right, okay.

MR GLOVER: Q. If we go back to page 13, after a diversion into acronyms which is impossible not to do in this Inquiry, 3.3. Just have a read:

> *Better patient outcomes derived from existing, developing and new ways of working are showcased.*

There are four points under that one?
A. Mmm-hmm.

Q. Is that also an area that your office has involvement in?

A. The communities of practice?

Q. Yes.
A. We have nursing-specific, this talks about multidisciplinary, but a nurse practitioner adviser has a rural nurse practitioner community of practice; we have a midwifery community of practice. They look at models of care and how they develop models of care across the sites. So it's actually something we engage in. We also link in with the ACI, so their communities of practice. If there are things that are occurring from a nursing midwifery point of view, they may come to us with specific things that they want to discuss.

Q. Over to page 15, please. 5.1:

There is a pipeline of future-ready workforce enabled by accessible and accurate statewide workforce data.

There's another four points there?
A. Mmm-hmm.

Q. Is this an aspect of the plan that your office has engagement with?
A. That's probably - yes, that is - that will be, yes, making the modelling data available to our nurses and midwives, that's what we're working with workforce planning. They're taking the lead but we're in there with them, yes.

Q. When you say you are working with workforce planning on that piece of work, how far advanced is it?
A. They have - they've started - I think they've done the initial modelling and what will be occurring is they're going out to the districts to start to test that with them. It's quite a big piece of work and I think they've scheduled - I'm hoping I'm correct - about an 18-month piece of work where they're actually engaging and testing.

Q. This is the piece of work being lead by Mr Griffiths' team; is that correct?
A. Yes, so they'll be able to give you more information on that.

Q. Thank you. The last one I want to ask you about in this document is 5.3 on that same page:

Closed workforce gaps in rural and remote areas in collaboration with local stakeholders.

There are a number of points there. Just take a moment if you need to refresh your memory about them.
A. So I guess some of that is about us talking about the experience of particularly our new graduate nurses in rural/regional areas. What we hear from them, that they're able to, I guess, function in a way that that they may not in the large metro areas, so they get exposed to different skill sets so those are some of the messages that we actually will share and promote with regard to that. So if I look at some of the things there. The vocational - well, that's the medical workforce, but certainly working and having conversations with the TAFE around enrolled nurses and pathways for enrolled nurses; and I guess an awareness from what the LHDs are doing as well around engaging with universities to provide opportunities as well.

THE COMMISSIONER: Just while we're on that page, and it's a complete tangent and please forgive me, Ms Cross, for going on a tangent, but when Dr Spooner was giving his evidence there was a discussion with Mr Fraser about the use of modelling for workforce planning. I can just see 5.1, the third bullet point, is "Use data analytics to better support workforce planning approaches". We might find out what that involves because data analytics can litter really just be the analysis of data, but it can also involve modelling.

MR GLOVER: Yes.

THE COMMISSIONER: So we might make a note of that and see where the LHDs - SHNs, what is that?

MR GLOVER: Specialty health networks.

THE COMMISSIONER: Where they're up to in using data analytics and what kind of data analytics.

Q. Sorry for that interruption; it's just that I would have forgotten to say that --
A. That's okay.

Q. -- if I hadn't interrupted your evidence.

MR GLOVER: Q. Those are the particular parts of this document I wanted to take you to but you did say at the beginning that your office has a part to play in it. Are there any other parts of this document that your office is particularly involved in delivering?
A. We mentioned - I think I mentioned the Aboriginal workforce, so I think that's - yes.

Q. You mentioned in your evidence and in your statement some of the challenges associated with recruiting to midwifery positions --
A. Mmm.

Q. -- and positions in rural and regional areas. Are there any other challenges that you see at the moment facing the nursing and midwifery workforce in NSW Health?
A. There's - I guess mental health, is something that sort of has - you know, again it's sort of a highly specialised area. So that has at - at times can be quite challenging. Again, that's why we embarked on the mental health pathways in practice. That was one of the very first ones that we did.

Q. So just pausing there, recruiting nurses with particular expertise in mental health?
A. Mental health nursing. Yes, sorry, yes, to work in the mental health facilities, yes.

Q. Yes, I understand.
A. And so, yes, we - that's why we embarked on that, really supporting mental health nurses, and nurses outside of mental health as well, to hone their skills as well, so becoming that sort of therapeutic type relationship that they have with the clients as well. That was the very first pathways in practice that we actually produced. That's had a good uptake, and we're now seeing, I'm told by the principal adviser in mental health, an increase in the number of mental health nurses applying for postgraduate scholarships. So that was the aim. We really want to engage and to develop them in particular chosen specialty.

Q. Aside from that further example, are there any others?
A. Look, I think there can be pockets at times, so, you know, post COVID - actually, I probably haven't got any facts on that so I won't talk about that, but at times, you know, operating theatres or our critical care areas might

be challenging, at different times in different sites, but I guess it also comes down to the work that the local health districts do in making sure that that pipeline stays strong. So utilising our new graduate nursing workforce, getting them on to a pathway into some of those more advanced areas as they progress through their careers as well. And we have seen that adaptability post COVID, that we were able to actually skill up nurses to work in some of the other critical areas as well.

Q. What sort of visibility do you have, in your position, of these particular pockets of workforce need or challenge?
A. Yes, oh, well, I think it comes from the relationships that we have with the local health districts, so the conversations that we're having, particularly for us with the LHD directors of nursing and midwifery. So they, in the conversations, will alert us to things that are occurring. There could also be things from, you know, workplace relations or workforce planning and talent development, that awareness where there might be some pockets of challenge as well.

And I think, as I said before, the other thing that we do do is when districts have come up with innovative models around how to support the workforce and grow the workforce, we sometimes are able to lift that up and scale that, and as I spoke about before, the rural pathway in practice is a good example of that.

Q. Are you given, in your position, any data or analytics on the nursing workforce across the system generally?
A. I am able to get that from workforce planning and talent development arm as required, but I think that, yes, I guess it really is about hearing from the districts around where they might be having issues. And sometimes it might be in a dedicated area or it could be something like midwifery that is actually broader. So it's about understanding that.

Q. The last thing I want to ask you about is paragraphs 68 to 70 of your statement.
A. Yes.

Q. You tell us about work under way to explore opportunities to amend legislation?
A. Mmm.

Q. To enable nurse practitioners to operate at their optimal scope. Can you give a general description of the work that is involving review of legislation and the like, but just invite you to expand on what that work involves but also where it is up to?
A. Yes. So we have engaged with the legal branch within the ministry. We've had feedback from nurse practitioners that there are things that they're not able to do, and it's because of legislation, it says a medical practitioner needs to be involved in that. So one of the examples that I used there was within Work - what is it? Sorry, I went blank. So WorkCover legislation. So really, if a patient comes to an emergency department, the nurse practitioner might not be able to actually provide them with that certificate, which means they'll have to go to a GP. So really we're trying to provide greater access to care.

What we've done is gone through all of the - well, the legal branch have gone through all of the pieces of legislation where it says a medical officer can do something, and we're currently reviewing that to see if it is appropriate for a nurse practitioner to do that also. So that's a large piece of work. So we're currently in the process of reviewing those pieces.

Q. And what's the end goal for that piece of work?
A. Well, the end goal would be if we can, would be to change some of that legislation to enable nurse practitioners to work in - well, to fill some of those roles, yes, which to us means greater access to care.

MR GLOVER: Thank you, Ms Cross. I have no further questions.

THE COMMISSIONER: Q. The WorkCover example you gave is just one example?
A. It is, yes, yes.

THE COMMISSIONER: We might follow up with a request about what else is being looked at in terms of possible legislative amendments.

Do you have any questions, Mr Chiu?

MR CHIU: I do not.

THE COMMISSIONER: You do not?

MR CHIU: I do not.

THE COMMISSIONER: Thank you very much for your time, Ms Cross. We're very grateful. You are excused.

THE WITNESS: Okay, thank you.

<THE WITNESS WITHDREW

MR GLOVER: The next witness is Ms Dewhurst.

<EMMA-KATE DEWHURST, affirmed: [3.22pm]

<EXAMINATION BY MR GLOVER:

MR GLOVER: Q. Ms Dewhurst, could you state your full name, please?
A. Emma-Kate Dewhurst.

Q. You are the director of occupational therapy at the Illawarra Shoalhaven Local Health District?
A. That's correct.

Q. To assist the Commission in its work you made a statement on 10 July 2024; correct?
A. Correct.

Q. That's [MOH.0011.0018.0001]. It is being brought up on the screen on the right but if you have a hard copy feel free to use whichever is most convenient. Have you had a chance to lead it before giving your evidence today?
A. I have.

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

Q. If I can take you straight to paragraph 6, please, there you tell us about the district-wide planning process in which the district targeted key areas to expand the allied health workforce?
A. Mmm-hmm.

Q. Can you just describe in general terms how that process unfolded and what it involved?
A. So we brought a range of allied health professionals.

We've got 11 allied health professional disciplines within Illawarra Shoalhaven LHD. So we brought a range of level 1/2 to level 3 to senior managers together in a room and really tried to identify what were some of the really clear areas that we needed to tackle from a workforce perspective.

Q. When you say areas you needed to tackle from a workforce perspective, does that mean areas of workforce need or demand?
A. Yes, where there's gaps, where we need to focus, where we need to look at upskilling, where we need to look at maybe redeploying to different areas. Yes. Where there's opportunities for looking at improving clinical care.

Q. And that process produced the two plans that you referred to in that paragraph?
A. That's right.

Q. Do I take it, then, that as a result of that process there has been some work done to address those gaps and needs?
A. That's right, yes, so we've got it over a four-year period where we've got sort of tangible KPIs for each year.

Q. KPIs directed to what sorts of things?
A. Some of it will be data driven, so we need to look at sort of - it might be sort of opportunities for diversity within the workforce. It might be looking at things like flexible work practice to look at sort of workforce retention.

Q. And in terms of identifying gaps in the workforce and addressing them, how were the gaps identified as part of that process?
A. So it's - we've historically got sort of FTE, sort of full time equivalent, FTE, allocated to sort of specific hospitals or sites or wards, but then it's just ensuring that we do have a good representation of allied health across those sites and services.

Q. What about demand for services? Was that part of the process?
A. That's - that is, yes.

Q. How is that assessed and taken into account?
A. So we get referrals via EMR, so it'd be looking at

sort of number of referrals received, numbers of referrals that we're able to access, and then things like within the community space, looking at waiting list and how long patients are waiting.

Q. And is there a strong demand for allied health services across the district?
A. There is.

Q. Is there a sufficient workforce across the district to meet that demand at the moment?
A. I would say no.

Q. What particular areas pose challenges?
A. I think across the board, you know, it's whether or not we're looking at really trying to be proactive and looking at it within sort of the non-admitted space, really trying to look at health promotion but also then trying to tackle more of the access and flow challenges within our hospitals.

Q. And is the challenge for workforce driven by a lack of available positions or a lack of people to fill those positions?
A. I'd say both.

Q. If we come to paragraph 11 of your statement, please, there you tell us in the 2021/2022 financial year, approximately 12 per cent of the allied health FTE in the district was unfilled. By "unfilled" do you mean vacant?
A. Correct.

Q. They are positions that exist but not occupied?
A. Correct.

Q. That was for the 2021/2022 year. Do you have a sense of what it is in the following periods?
A. Yes, it's something we're able to provide but we have seen consistency around that same percentage.

Q. And what effect does --

THE COMMISSIONER: Sorry, I just need to go back. One of the questions you asked - it could be me just being dumb, but one of your questions was:

And is the challenge for workforce driven

by a lack of available positions or a lack of people to fill those positions?

And the answer was "both". How should I understand that?

Q. Does that mean there are positions that could be filled but you can't find people?
A. Correct.

THE COMMISSIONER: And does it mean anything beyond that?

MR GLOVER: Yes. So the first part, perhaps expressed poorly, but the first part of my question was directed to are there enough FTE within the district --

THE COMMISSIONER: For the demand for services?

MR GLOVER: -- to meet the demand?

THE COMMISSIONER: Yes.

THE WITNESS: I would say as demand continues to increase, we haven't been able to have the same trajectory of our FTE.

MR GLOVER: Q. I think you were telling us that the numbers in paragraph 11 have been fairly consistent in the subsequent periods; correct?
A. Correct.

Q. Does that have an impact on the delivery of allied health services across the district?
A. Yes.

Q. Just in general terms, what is it?
A. So where there are gaps, that's when we need to look at sort of continuing to provide care where needed, but that obviously means that we need to look at using our triage tool to ensure that the most appropriate or the patient of highest need is seen, but then that means that there are some patients who aren't necessarily always able to be seen.

Q. Are there any pieces of work directed to addressing these percentage of vacancies?
A. Yes. So definitely our ISLHD allied health workforce plan, which looks at things like career progression and

looking at how we can support our staff progress their careers for things like clinical expertise, research, management are all opportunities from an attraction and retention perspective.

Q. And is part of that response to attract allied health professionals in their training phase to the district?
A. Yes. So we work closely with our universities. They are a strong part of - they are our future workforce, so yes.

Q. And when you say "work closely" with universities, what types of initiatives are being undertaken to attract students from those universities to placements within the district?
A. So I know from - in terms of I'm a part of the OT state advisers and I know that the speech pathology advisers also have looked at providing an annual or biannual webinar, "Start your career in NSW Health", which is open to all university students, undergraduate 3, undergraduate 4 or MOT2, who are able to come and learn about starting their careers in NSW Health, so we're looking at that as an attraction strategy.

Q. In paragraph 14 - and this is in the context of occupational therapists - you tell us that attracting and retaining occupational therapists has become more competitive because there's now a career path in the private sector?
A. Correct.

Q. Is that something that has developed over the years in recent years?
A. It's been definitely a challenge since the NDIS has looked at that being an opportunity within sort of the OT career, so yes, it's definitely become a challenge.

Q. And are you aware of some of your colleagues who have left the public system to take up those opportunities?
A. Yes.

Q. And are you aware of any work being done to counteract those market forces?
A. Yes.

Q. What is it?
A. I know within our OT leadership team we've looked at

things like how we can really ensure that flexible work practice is something that we are not just preaching but we're really embedding as an opportunity for those that may have gone across to the private sector just because they felt that they were able to get additional arrangements to support them and possibly their family. We've got sort of a roughly about 82 per cent female workforce, so they are able to receive additional flexible work practice in that sector.

Q. So I take it from that answer, it's not only financial rewards that are attracting staff to the NDIS opportunities?
A. No, it's not.

Q. It's other workplace conditions as well?
A. Correct. Correct.

Q. In paragraphs 15 to 20, you tell us about the clinical placement of students within the district. Are you familiar with how that process operates?
A. Yes.

Q. Just in general terms, how does an allied health student come to be placed in a placement within the district?
A. So we use a platform called ClinConnect where universities will request placements and then the LHD will accept them; then it goes back to the university to reconfirm; and then we do that one more time to confirm that we've still got capacity to take a student; and then they will come during their specified clinical placement time.

Q. Is there any work done to try to attract students to placements within the district?
A. I don't necessarily feel we need to attract them. There's definitely a large number of students that would like placements within sort of that hospital setting to gain really core clinical skills before they finish their undergraduate.

Q. In paragraph 19, you tell us that you've noticed the building of new hospitals or redevelopment often does not result in corresponding space allocation for allied health students. Do you see that?
A. Correct.

Q. What is that based on?
A. I know we've just been going through the process to look at a new build within our LHD but also a redevelopment and we've definitely been trying to advocate enough space for our actual clinicians, let alone our students.

Q. And if there were that space, would that have an impact on the amount of training that could be delivered?
A. Yes.

Q. In what way?
A. So we'd be able to increase the number of students that we have because we're able to accommodate them from a space perspective, a work space perspective, but also from an IT and computer perspective.

Q. And would there be benefits to the district, in your view, if more training was being able to be delivered to allied health students within its facilities?
A. Yes.

Q. What are they?
A. We would be able to look at sort of student-led clinical programs that could look at maybe tackling some - it might be some non-admitted, you know, large waiting lists where we could look at sort of some student-led outpatient programs within that setting.

Q. What about in terms of attracting those students once they qualify to roles within the district?
A. That would be another, yes, attraction strategy that we could use, yes.

Q. In paragraph 20 you observe that, as with other health provisions, the demand on supervisors to be able to supervise whilst also maintaining a clinical caseload can make it difficult to attract supervisors and support students?
A. Mmm.

Q. Just in practical terms, what's the challenge that you're referring to there?
A. Just definitely within the in-patient space, access and flow is a real focus area where we need to really try to get through as many patients as we can in a day, so having that time to be able to sit and work with a student

to be able to ensure that they are getting the support that they deserve is a challenge. That's where I suppose it depends on whether or not there's access to, say, a level 4 student educator to be able to provide that support to the student supervisor as well as the student.

Q. Is there anything that could be done differently, in your view, to support both the clinician and the student in that context?
A. I definitely think the student educator is a pivotal part to be able to ensure that the student is receiving the support that they need, but it also allows the clinical supervisor to be able to have some time to really just churn through some of their caseload as well.

Q. Can you just describe the role of the student educator for us?
A. They have a role in being able to look at coordinating student placement but as well as organising, might be - we've got a number of students at any one time, organising orientation, on-boarding. Then also it might be looking at that sort of student-led programs that they might be involved with, so that then one student supervisor might be able to supervise a number of students at one time, which is obviously advantageous when we're trying to get through a number - you know, have as many student placements as we can.

Q. And are these employees of the district?
A. Ideally. I know that there are some arrangements that might be part funded by the university, correct.

Q. In section (c), the first paragraph under section (c), you tell us about HETI and you describe some grants. Do you see that?
A. Yes.

Q. Just by way of clarification, these are grants from HETI to fund training delivered by external providers; is that right?
A. Correct, correct.

Q. Are there any other grants available to the district to support training in allied health?
A. There are some rural grants that do come up.

Q. What are they directed to, do you know?

A. They're not as regular. These HETI grants are definitely what we really look forward to to really strategically determine how we can address some of the education and training needs of our LHD. So they're our key opportunity to look at how we can get external presenters to help upskill our LHD from an allied health perspective.

Q. Is it only the funding of external training that those grants can be directed to or it can be directed --
A. Yes, that's part of the terms and conditions.

Q. Are there any grants or support available from HETI to develop internal training within the LHD?
A. Not in - I'm - not that I'm aware of, no.

Q. Aside from grants of the kind you've described in that paragraph and the following two, are there any other supports provided by HETI to allied health practitioners?
A. They do look at every year requesting some priorities from an LHD perspective - that's not allied health specific but across the board - where we're able to put in requests of what we see as a priority to be included in My Health Learning. That's another opportunity that HETI provide.

Q. My Health Learning is a virtual online platform, is it?
A. Correct, yes.

Q. In paragraph 28, you tell us that universities support their allied health students while on clinical placement. Can you just expand on that? What do you mean by they support their students?
A. Often remotely, they would be looking at being a source of contact, if a student needs it. I wouldn't necessarily say it's sort of proactive onsite support, but definitely where there are possibly students that are at risk of failing, that's when we really would work collaboratively with the university to support that student.

Q. And then you tell us that universities offer specific education to NSW Health allied health professionals on how to provide effective clinical supervision.
A. Correct.

Q. What form does that support take to the clinicians who

are supervising?
A. It would look at possibly onsite or virtual training on how to manage, say, it could be a student who is at risk of failing and how we can, as clinical supervisors, support our students go through that process.

Q. And then the last sentence of that paragraph, you say, however, that the universities offer very few educational opportunities to NSW Health allied health professionals on clinical specific skills. Do you see that?
A. Correct.

Q. What sort of opportunities would you like to see, whether it be from universities or other training providers in that area?
A. I think in terms of universities, they're at the forefront of, you know, what we look at as terms of evidence based practice. So any opportunities where there's an ability to share their new learnings would be wonderful. It might even be a matter of subsidising some of their CPD opportunities that are run through the universities for those that do take on their students.

Q. If you can turn ahead to paragraph 31, please, in the first sentence, you tell us that the district allied health recruit to positions as unfilled hours arise as opposed to proactive recruitment drives due to the formal approval process that includes finance confirming unfilled FTE. Do you see that?
A. Yes.

Q. Can you just describe in practical terms the issue that you're raising there and why it's a challenge?
A. Yes, sure. So we might have someone who puts in their resignation, they give the four weeks' notice. We'll put in an ATF in the portal, it's called ROB. It's got to go through quite a process to be able to then even put up to our advertising it, finance have to confirm that there is actually a vacancy linked to that position, and then there is quite a lengthy process to be able to get a successful applicant to commence placement - to commence employment.

Q. And that process might extend beyond --
A. Correct.

Q. -- the resignation date. Is that the issue?
A. Yes. Regularly would.

Q. Is that an issue that's been raised within the district to your knowledge?
A. Yes.

Q. And is there any work that you are aware of being done to address it?
A. Yes. In terms of workforce, you know, they are quite motivated to look at how they can meet their 40-day KPIs and we do work quite closely with them where we really feel like we need to prioritise a specific position. But obviously there are things that are out of their control, things like police checks, for example, that are out of their control.

Q. Do I take it from that passage of your statement and the answers that you've given, that you would see considerable benefit in the recruitment process being pursued in a way that would see staff being replaced as soon as the former incumbent finished their work?
A. Yes.

Q. If you turn ahead to paragraph 36, please, you touched on this in the NDIS context.
A. Mmm-hmm.

Q. There you tell us about the increasing number of opportunities external to health which offer high salaries and more flexible working practices, et cetera. Aside from NDIS, are there other challenges that the public health workforce faces in retaining its staff?
A. I think there has definitely been almost a bit of a cycle within occupational therapy where we do sort of recruit new graduates, we upskill them, they move from a level 1/2 to a 3, and then possibly, you know, become this experienced clinician. And we do have, like I said, the 32.5 per cent female workforce that then would look at - go off on maternity leave and work part time possibly for the next five-plus years and then look at heading over to either an NGO or a private provider via NDIS. There are times as well that they might do part health, part-time health, part-time private as well.

Q. Is there anything the system could do to assist in retaining those allied health professionals in your view?
A. I think definitely looking at career progression is one; looking at sort of inclusion and recognition of ways

that we could look at diversifying our workforce; and then looking at really how we can proactively manage workload to look at reducing risk of, say, burnout.

Q. Is there work being done in those areas that you're aware of?
A. Yes.

Q. What is it?
A. So we have - we've got workload guidelines looking at sort of percentage of clinical time that we utilise to open communication channels with clinicians that could look at not just sort of not meeting their percentage of clinical time but possibly working above and beyond, which means that there are times that often we've got clinicians working through lunchtime, working into the evening to meet their clinical demand, so it's having that discussion of how we can really ensure that they're working - maximising what they are doing but also not at risk of burnout.

Q. If we turn over to paragraph 38, there you tell us, in your view, that allied health professionals do not have access to the same opportunities in terms of recruitment incentives. What did you have in mind?
A. So one option is we've attempted to look at, say, recruiting through recruitment agencies and there's just - due to the financial commitment, that's not something that we're able to progress with.

Q. Why would recruiting through a recruitment agency be beneficial in your view?
A. Especially for hard-to-fill positions, where we might have someone who, through a recruitment agency, is more willing to look at moving to some of our hard to fill positions, possibly within our sort of regional or rural positions.

Q. Do you have any other recruitment incentives in mind?
A. I know there's the rural health incentive, is an option that we've had some success with.

Q. Some but not enough, in your view?
A. I think it's hard to demonstrate that either - that it's hard to fill. Often we have - we might move a clinician from one site to the next to address a gap and ensure that we're addressing clinical risk but then that - so we've left one gap, but then we've moved it to where

we've really needed it, but that then is hard to then provide evidence to demonstrate that it is vacant.

Q. So is what you are describing a lack of flexibility in the incentive scheme --
A. Correct.

Q. -- that particularly bites in allied health; is that right?
A. Yes.

Q. Are there any other recruitment incentives that you see could be beneficial if offered to allied health professionals?
A. I think the really embedding flexible work practice is one thing that we are working on and I think we can continue to work on as a strategy.

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

THE COMMISSIONER: Do you have any questions, Mr Chiu?

MR CHIU: On one issue, Commissioner.

<EXAMINATION BY MR CHIU:

MR CHIU: Q. On that issue about flexible workplace practices, do you have any comment as to whether the awards that apply to allied health professionals in the public health sector, whether they assist or hinder flexible workplace practices?
A. I think as a manager I can say it's often a challenge to ensure that we are working within, say, our leave matters policy but also within the award, so it's really important that we know who to contact from, say, a payroll perspective or a workforce perspective to ensure that we're still being compliant with a lot of these policies or awards.

Q. But aside from ensuring compliance, have you had, as part of your experience, difficulty in being as flexible as you would like because of the reality of what the awards permit?
A. Yes.

MR CHIU: No further questions, Commissioner.

THE COMMISSIONER: Nothing arose out of that?

MR GLOVER: No, Commissioner.

THE COMMISSIONER: Thank you very much for your time. We're very grateful for you coming, and you are excused.

THE WITNESS: Thank you.

<THE WITNESS WITHDREW

THE COMMISSIONER: So 10 o'clock tomorrow?

MR GLOVER: Yes.

THE COMMISSIONER: All right. We will adjourn until 10 o'clock tomorrow, thank you.

AT 3.48PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO WEDNESDAY, 24 JULY 2024 AT 10AM

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