Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

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

Monday, 14 October 2024 at 10am

(Day 054)

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 SC for NSW Health

THE COMMISSIONER: Just before we start, because it is a new hearing block, can I acknowledge the Gadigal people of the Eora Nation, the traditional owners of the land on which we gather today, and pay my respects to their elders past, present and emerging.

MR MUSTON: The first thing I was going to raise before we come to the evidence, I understand that an affidavit's been provided by the ministry in relation to some aspects of timing. I don't know whether Mr Chiu of senior counsel would like to come and address that briefly before we get going.

THE COMMISSIONER: Sure, yes.

MR CHIU: Commissioner, if you don't mind, I have the honour to announce that I have been appointed as senior counsel for the State of New South Wales, taking rank of precedence next after my learned friend Fionnuala Marie Therese Simpson.

THE COMMISSIONER: Congratulations. It is very well deserved. Like the answers to many of your questions, I actually knew before you did. You are not meant to betray confidence of these things but I can guarantee you it was nearly unanimous.

MR CHIU: Thank you, Commissioner.

As for the second matter, as counsel assisting alluded, an affidavit of Nigel Joseph Lyons sworn 3 October 2024 was provided to the Commission.

That affidavit sets out some difficulties, practical difficulties, that NSW Health has in meeting a submissions deadline at the end of January and respectfully seeks a period of extension into February. I just thought I would put that on the record formally.

THE COMMISSIONER: The only thing I will say about the affidavit today is that I accept all the factual basis, obviously, that is set out in the affidavit.

I also accept the genuine belief for the need for the extra time. One means of overcoming the issue which I am happy to share is that because of this request, we have, or I have, written to the minister seeking a three-week

extension on the reporting date which would accommodate the period of extra time that is being sought through this affidavit.

I don't know what will happen there. So what is being sought is to change the report date from 26 March to 24 April, because Easter accounts for the extra bit from three weeks, on the basis that there won't be any more hearings, there won't be any more evidence taken, it will just enable the Inquiry team, if you were to supply what you want to supply by 18 February, to properly consider and include in the report your submissions and responses to draft recommendations.

I don't know what the answer to that will be but if the answer is "No", which is one of the possibilities, I won't make a formal ruling today, but it would be very difficult to accommodate the extension sought, the reason being that, on the current timetable, the report goes to the printers on 26 February, which would leave four business days to consider Health's submissions and response to draft. So we could read them but it wouldn't be reflected in the report. So that's what we have done at our end.

That was communicated a week ago now. Hopefully, we will hear during the course of the week what the government's position is on that and I will let you know straightaway. Then I will still hear anything further you want to put to me regarding the affidavit and the need for this extra time before I make a final ruling. I'm just saying if there is no extra time for the report, it is going to be very difficult to accommodate.

MR CHIU: I understand. Thank you, Commissioner.

THE COMMISSIONER: Thank you.

MR MUSTON: We are embarking upon the second of our workforce hearing blocks. As it is a continuation of the last I won't detain us too long with any formal opening but perhaps give some indications just of the proposed format.

What we endeavoured to do through the first block of the workforce hearings was identify some of the key challenges which are experienced in different - workforce challenges, that are experienced in different aspects of

the public health system and perhaps different segments in the workforce pathway within the public health system.

They were identified in an issues paper which was circulated widely and responded to by a range of interested parties. What we're proposing to do during this hearing block is to bring together panels, effectively in a roundtable type arrangement, although as you see in front of you, it is not round. We are somewhat constrained by our physical environs.

The idea is by bringing together different interest groups within particular subject areas we're hoping that we can explore some potential solutions that they have brought forward and to the extent that there are different views amongst different interest groups, whether it be the ministry, education providers, clinicians or industrial organisations about what solutions might work, what might not work, we see this as an opportunity for us, and them as between themselves, to tease out some ideas and to see if we can find some common ground, and to the extent there is not common ground and there is difference, we will understand what the difference is.

The first panel deals principally with the nursing workforce and, in particular, has a focus on the education of the nursing workforce and the way in which that impacts on the pathway and workforce challenges, including shortages and maldistribution.

The people in front of you, from your left to your right, are Professor Kathleen Baird, who is the head of nursing at University of Technology, Sydney; Richard Griffiths, the executive director of workforce planning and talent development at the ministry, who we have heard some evidence from before; Michael Whaites, the general assistant secretary of the NSW Nurses and Midwives Association; Jacqui Cross, the New South Wales chief nursing and midwifery officer, who again we heard some evidence from in the first workforce hearing block; and Jacqueline Dominish, from the health professionals workforce within the ministry. Again, we've heard some evidence from her already.

I understand that each of them is happy to take an affirmation. What we were proposing is if the affirmation is read once, they could each seriatim say "I do", without

having to go through the motions separately for each of them, but, of course, that is entirely a matter for you.

THE COMMISSIONER: I'm happy to adopt that process.

<KATHLEEN MARION BAIRD, affirmed: [10.09am]

<RICHARD RONALD GRIFFITHS, affirmed:

<MICHAEL JOHN WHAITES, affirmed:

<JACQUELINE MARIE CROSS, affirmed:

<JACQUELINE ANNE DOMINISH, affirmed:

MR MUSTON: I might start with you, Professor Baird. Could you state your full name for the record, please.

PROFESSOR BAIRD: My full name is Kathleen Marion Baird.

MR MUSTON: And you are the head of nursing at the University of Technology Sydney?

PROFESSOR BAIRD: I'm the head of nursing and midwifery.

MR MUSTON: Nursing and midwifery, I'm sorry. You have contributed to a statement prepared by the University of Technology, Sydney?

PROFESSOR BAIRD: I have, yes.

MR MUSTON: Which is, I think, exhibit L18, Commissioner.

Insofar as you are aware, are the contents of that statement true and correct?

PROFESSOR BAIRD: Yes, they are.

MR MUSTON: Moving to you, Mr Griffiths, would you state your full name for the record.

MR GRIFFITHS: Richard Ronald Griffiths.

MR MUSTON: You are the executive director of the workforce planning and talent development branch within the ministry?

MR GRIFFITHS: Correct.

MR MUSTON: You have prepared three statements to assist the Inquiry, two of which were tendered in the first hearing block as H5.21 and H5.21.2, but you have prepared a further statement, I think, dated 8 October 2024?

MR GRIFFITHS: I have.

MR MUSTON: You will find that, Commissioner, at exhibit L7.

Insofar as you are aware, are the contents of that statement true and correct?

MR GRIFFITHS: Yes.

MR MUSTON: Thank you.

Mr Whaites, could you state your full name for the record.

MR WHAITES: Michael John Whaites.

MR MUSTON: You are the general assistant secretary of the NSW Nurses and Midwives Association?

MR WHAITES: Correct.

MR MUSTON: You have not prepared a statement. Your organisation has prepared a submission which has been provided to the Commission?

MR WHAITES: Yes.

MR MUSTON: Were you involved in the preparation of that submission?

MR WHAITES: Yes.

MR MUSTON: You have read the submission recently?

MR WHAITES: A significant proportion of it, yes.

MR MUSTON: That portion you have read, insofar as you are aware, the contents of it are true and correct?

MR WHAITES: Yes.

MR MUSTON: Thank you.

THE COMMISSIONER: This is the submission of November 2023?

MR MUSTON: Yes. Sorry, I should have said that.

Ms Cross, your full name for the record, please.

MS CROSS: Jacqueline Marie Cross.

MR MUSTON: You are the chief nursing and midwifery officer within the ministry?

MS CROSS: That's correct.

MR MUSTON: You prepared a statement for us dated 8 July 2024 which was tendered in the first workforce hearing as exhibit H5.10. You haven't prepared a further statement for the purposes of this?

MS CROSS: No, I haven't.

MR MUSTON: And finally, Ms Dominish.

MS DOMINISH: Yes.

MR MUSTON: Your full name for the record.

MS DOMINISH: Jacqueline Anne Dominish.

MR MUSTON: Because what is written down on my sheet of paper does not make perfect grammatical sense, could you tell us exactly what your role is within the ministry?

MS DOMINISH: I am the director of the health professional workforce and the unit that it's responsible for.

MR MUSTON: Thank you. You prepared a statement dated 5 July 2024 which was tendered during the first round of workforce hearings?

MS DOMINISH: Correct.

MR MUSTON: That was exhibit H5.9, Commissioner.

And you have prepared a further statement, I think, dated 2 October 2024?

MS DOMINISH: Correct.

MR MUSTON: You have had an opportunity to read that statement?

MS DOMINISH: Yes, I have.

MR MUSTON: Are you satisfied that the contents of it are true and correct to the best of your knowledge?

MS DOMINISH: Yes, I am.

MR MUSTON: That, Commissioner, is exhibit L.1.

That's the formalities over with. Let's turn to the substance.

As we understand from the evidence given to date, both during the first block of workforce hearings and through our regional hearings, within the nursing and midwifery workforce there are two key challenges. The first is a significant shortage in the midwifery workforce. Does anyone have a different view to that which we have tentatively formed on that issue?

MS DOMINISH: No.

MR MUSTON: Before we move off shortages, what about the nursing workforce? Is there an issue with the number of nurses within the workforce? We will come to their distribution in a moment.

MR GRIFFITHS: Maybe if I respond. So our modelling indicates that the number of graduating nurses is in line with demand but that they are maldistributed. So the distribution is challenged but the number leaving universities is appropriate to meet demand. We've modelled that through to 2040.

MR MUSTON: Ms Dominish, you wanted to add to that?

MS DOMINISH: The only exception to that would be the enrolled nursing workforce where there is a significant

shortage to meet a load demand scenario in the future.

MR MUSTON: For the benefit of the Commission, could one of you in lay terms describe the difference between the registered nurse and the enrolled nurse in terms of training pathway and the general function that they serve within the public health system?

MS CROSS: Yes, I can do that. The registered nurses are educated to a higher level so they are at bachelor level and they assess, plan, execute the care. Enrolled nurses are a diploma level and they work under the supervision of the registered nurse, either indirectly or directly.

MR MUSTON: Does anyone on the panel have a different - want to add anything to that in terms of the training and general function of a registered nurse as compared with an enrolled nurse? No.

So just to make sure I've understood --

THE COMMISSIONER: Can I just ask, Mr Griffiths, the modelling for the demand is no doubt quite complex, but I assume, amongst the inputs are ageing population, disease profile of the community, chronic disease rates, et cetera.

MR GRIFFITHS: Yes.

THE COMMISSIONER: Tell me what else.

MR GRIFFITHS: So yes to all of those. We gather that information through our strategic planning unit in the ministry, so we look at demographic projections; we use ABS data; we use Commonwealth modelling as well. So we predict the ins and outs and obviously things like anticipated retirement, changes in the patterns of retirement as well, so if we look to see that the anticipated retirement age is increasing, we factor that into the modelling as well.

MR MUSTON: Did you want to add something, Mr Whaites?

MR WHAITES: I can't comment on the modelling, I defer to the expertise, but what we notice is, broadly across the state, vacancies and slow recruitment processes. We see rosters that have vacancies forward in them at a great rate. It's not clear to us as to whether or not the modelling that is done takes into consideration the award

requirements for staffing levels as set out under the Nurses' and Midwives' (State) Award, and if the numbers coming out of university are projected to be okay, there still seems to be a disconnect with the numbers of nurses and midwives actually working on the floor. So there is a question there for me.

MR GRIFFITHS: I'll just add that it does factor in any sort of mandated levels of staffing. So we are adjusting that, obviously, as we roll out safe staffing levels, but it does factor that into the modelling.

MR MUSTON: In terms of the vacancies that Mr Whaites has referred to, is that a manifestation of the maldistribution that you identified earlier? I suppose question one: do you agree that there are vacancies rolling forward in shifts? Is that what your data shows you?

THE COMMISSIONER: And what kind? Are the vacant positions still - are there agency staff, for example, in that position, rather than the position actually not having any human being providing the healthcare services?

MR GRIFFITHS: It is a very good question, Commissioner. I think in my tranche 1 evidence, I talked about some of the challenges of getting that level of visibility as to whether or not we do have a snapshot of vacancies that are unfilled. The vast majority of our vacancies are filled in some way, either with increasing part-time hours, using overtime or using premium labour through agencies.

There will always be vacancies. In an organisation of 180,000, you are going to have, at any point in time, several thousand vacancies with a turnover - a healthy turnover - and our turnover is sitting at about 13 per cent. So there is going to be some churn in the workforce.

I think I mentioned in the first tranche, while our turnover is at 13 per cent, we only lose, in terms of actual attrition, about 6.6 per cent from the health system. The rest of that is movement through the health system, which does obviously generate some vacancy as people move around. We're not necessarily losing them to the health system.

THE COMMISSIONER: It is my fault from distracting you,

but Mr Muston said in terms of the vacancies that Mr Whaites has referred to, is that a manifestation of the maldistribution that you identified earlier? Is that part of it?

MR GRIFFITHS: Yes, apologies, I didn't go back to that. Yes, it is.

Obviously the maldistribution does cause us some challenges in areas where it is not as easy to recruit, and so the lived experience of people in those units is obviously felt more significantly as well, because one vacancy in a small facility is a significant impact, as compared to a metro, where you are going to have thousands of nurses.

So, yes, it is; in relation to your question, it is a manifestation from the maldistribution.

MR MUSTON: Would it be right just to summarise these challenges - first, significant shortage in the midwife workforce; second, significant shortages in the enrolled nurse workforce; and, thirdly, maldistribution of the entire nursing and midwifery workforce, particularly in - well, leading to challenges in filling vacancies in rural and remote settings?

Does anyone want to add or elaborate on that as a series of key workforce challenges within the nursing workforce? Are there any others that any you can think of as key challenges which are causing problems in terms of the nursing workforce and filling vacancies, getting people into the areas that they need to be in?

MR GRIFFITHS: If I may, one of the other challenges is a fairly rigid use of registered nurses. There is an opportunity for us to really look at models of care that utilise other classifications of nurses, but our industrial arrangements limit us to requiring a certain number or ratio of registered nurses to patients.

I won't get into the union's argument around that, because obviously they're very passionate about the importance of that, but that does make it very difficult in some of those areas where you're supply challenged in terms of registered nurses, where we could safely utilise other models of care but we're prohibited from doing it because

of the industrial arrangements.

MR MUSTON: I anticipate, Mr Whaites, you will have something to say about that. Can I just park that and we might come back to it toward the end. Because that is obviously a utilisation of existing workforce, let's work through the pipeline from the point at which it begins in the educational space and then, once we get to that point where we have our population of enrolled nurses, registered nurses, assistants in nursing and the like out there in the system, we can have a discussion about differing views about how they're deployed.

THE COMMISSIONER: I know you want to park this, and I'm not seeking to undermine that, but just so I understand something that Mr Griffiths just said, when you say "we could safely utilise other models of care", what should I understand by that? It means a model of care, I assume, that doesn't need to utilise a registered nurse, but is there something more that I should understand by what you are seeking to say?

MR GRIFFITHS: No, I think your understanding is right. I think there are two ways that it can be interpreted as well. It can be other classifications of nursing workforce or other classifications of workforce more generally that are appropriately qualified to provide health services.

I'm not a clinical expert, so I would defer to Ms Cross, but there is evidence to suggest that there are safe models of care utilising other classifications in the nursing workforce that would help us in those areas where we are so supply challenged in terms of registered nurses.

THE COMMISSIONER: Ms Cross is nodding her head. Do you want to follow this up later or should we ask now?

MR MUSTON: Let's deal with it now.

THE COMMISSIONER: What would you like to add to that, Ms Cross?

MS CROSS: It really does come down to the nursing model of care, as we've spoken about. We have the registered nurses, the enrolled nurses and the AINs, and I think there are some models where we can move into that sort of team-type nursing as well, and certainly within the local

health districts there are examples of that in different areas as well. So it is about how we allocate the care and come together to provide that care as well.

I think it plays out in the conversation, and we might get there later on, around scope of practice, so enabling our registered nurses to work to their optimal scope, which would require the enrolled nurses, the AINs, providing some of the other care, personal hygiene care, things like that.

MR MUSTON: Ms Dominish?

MS DOMINISH: I will just make one comment and again we might get into the detail about this later, but all models of care - in this case around nursing models of care - need to be responsive and adaptable to the local context and the patient, I suppose, profile that is coming in to or being serviced in those communities. So whether it's in that population or in that clinical area.

So there is a challenge by having a fixed, rigid method of saying, "This is the way you must staff something", that doesn't necessarily account for the changing needs of the patient population and the way in which the health system delivers care to that population.

THE COMMISSIONER: What should I understand by that, that the important matters are what are the healthcare service needs and can they be delivered safely, which might involved different models of care and different classifications of clinicians?

MS DOMINISH: Correct. And you are ensuring that in that recipe of ingredients you've got, in your humans, that you're making the best value of each of those individual persons' skills, so that when you put it all together it is effective and it is an enjoyable environment for the staff to work in and also a good outcome for the patients.

MS CROSS: Can I just add that the other thing is, I guess, that workforce pipeline. An assistant of nursing will go on to become an enrolled nurse. The enrolled nurse pipeline is a very healthy one to go on to become a registered nurse as well. I think that's particularly effective in our rural/regional areas as well, pertaining to that "grow your own" focus as well.

MR MUSTON: Mr Whaites, we have broken the seal on this topic so do you want to say something? I anticipate you might have a subtly different view.

MR WHAITES: Where to start? I think the portrayal of a nurse to patient ratio system as being rigid and inflexible is, to be frank, ideologically driven. We have a number of ratios approaches, that are dependent on the type of service, the size of the service and the complexity of the service. The ratios approach also envisages models of care. It doesn't drive away from that. And where we do have percentages of registered nurse to other classifications, that is evidence based, research based. It is not association ideology.

We have decades of evidence that shows that once you get below an 80 per cent RN skill mix in an acute care setting, your morbidity and mortality starts to increase. We have evidence to show that when you have nurse to patient ratios in place, actually, the patient outcomes are better and because the patient outcomes are better it is more cost efficient to the healthcare service.

The question of pipeline as it relates to the utilisation of AINs, ENs and RNs we are very cognisant of. It used to be that nursing was a way out of poverty for people. You could work as an assistant in nursing whilst you did your enrolled nurse training. There were no costs associated with that. You went through TAFE, you had hospital-based clinical practice and experience and then you could go on to university, again, fee free, and become a registered nurse, move from, you know, no employment to secure long-term employment in the public sector.

We have a lot of enrolled nurses who now tell us that the length of the courses, cost of the courses and the wage differentiation from being an enrolled nurse level 5 to being a first year registered nurse is not economically viable for them.

We also see in the small regional towns where it could be of most use, you will have someone who is an enrolled nurse but there is no registered nurse position for them to go into. So to give up their enrolled nurse position would mean relocating their family at times that's not appropriate.

I think there is an awful lot to say on this, but to present ratios as rigid and inflexible and a barrier to pipeline is not accurate.

MR MUSTON: Can I ask in relation to that, you said that you have a number of ratios and approaches that are dependent on the type of service. Where do they sit in terms of - let's say we're dealing with a small rural MPS that might have predominantly an aged care population with a small emergency department on the side, where does one go to to find the ratios that are applicable to that setting as distinct from, say, the emergency department at a busy city hospital like RPA?

MR WHAITES: For the level A, B and C facilities, we have a one to four ratio - the skill mix varies depending on the nature of the Cs. For the tiny hospitals that you are proposing, we merely require that there be at least two registered nurses on duty 24 hours, and we put that claim to the government, the government has agreed to that, because in a number of those facilities, after 4 o'clock, 5 o'clock, you would only have two people in the entire hospital.

Both of those under the award ought to be a registered nurse, but often it is a registered nurse and an enrolled nurse or a registered nurse and an AIN, and when someone presents to the ED, both of those staff members are required to be in the ED at times depending on the incident they are responding to, which leaves the rest of the facility unstaffed. Now, we know that those EDs, they don't take retrievals, the ambulances don't tend to go there but the locals tend to turn up, and so they can and do deal with category 1 episodes requiring both people to be in the ED for quite some time.

So the only call that we have put in those facilities is that there must be two registered nurses on duty 24 hours in order to allow for a third person to be in the rest of the facility and for any category 1 or emergent situations to be dealt with.

One of the barriers to recruitment that we hear from members in those facilities is registered nurses turning up, making the jump to move to a regional/remote area, and then realising very quickly that they are the only person on duty with any significant qualification, all

responsibility falling back to them. There's no on-call systems. Very often people, other staff members, live a distance away from the hospital, and so they will just not accept that level of responsibility and risk to their registration, so they don't hang around.

So having at least two RNs on duty 24/7 we see as safer for the community and more able to attract people to stay, because they can practice safely.

MR MUSTON: Could I ask you, Ms Cross, to perhaps respond to two aspects of that. The first is the idea that ratios might be inflexible in a way that prevents the implementation of what the ministry perceives to be a safe mix of nurse to patient ratio supplemented with enrolled nurses, AINs and other health practitioners - what is it about the existing system which creates the inflexibility, if I have understood you correctly?

MS CROSS: I think it's moving into the proposed ratio structure. So if we use AINs, an example of that is we currently use our undergraduate students in AIN roles, and certainly there is a model being piloted at Western Sydney Local Health District, Nepean Blue Mountains and South-Western.

They are fortunate because they do currently have some lines in their staffing profiles that they can utilise for the undergraduate AINs, but to actually expand that any further would be challenged, because there would be a limitation to the numbers of AINs that they're able to put on, particularly to the acute wards and the like.

So that's probably a very practical example of a challenge there around, I guess, any future thinking about how we can grow that undergraduate AIN model so we can help support that work-ready type example.

MR MUSTON: In terms of the proposition that ratios are inflexible, is built into that an assumption that in some circumstances, the existing or proposed ratios - and tell me which - are not necessarily required from a patient safety point of view?

MS CROSS: Sorry, I don't understand.

MR MUSTON: Let me take that back a step. As I understand

the evidence you've given a moment ago, the ratios might prevent an increased use of, say, assistants in nursing which, as we will come to, potentially has a strong value from a workforce pipeline point of view. What is it about the ratios that are preventing the system from employing more assistants in nursing?

MS CROSS: I see. Well, my understanding - Mr Whaites probably knows a little bit more - is that it is around the cap on how many you can actually have per unit. In the past you might have looked at what was happening in a particular shift or whatever and you might say, "We can actually accommodate one or two here, if we're unable to get other staff", where there will be set ideas around maybe you can only have one per ward, or I guess revisiting the models as well, that would be part of the negotiation, saying, "Well, we now think we can change that skill mix, that nursing skill mix", which will require negotiation. That's what normally would happen anyway.

MR MUSTON: I might need to unpack that. So from a ratios point of view there is a number of registered nurses per patient ratio which I think conceptually we can all understand within a particular facility.

MS CROSS: Yes.

MR MUSTON: Are there other ratios built into this?

MS CROSS: Then there's the staffing - the ratio, I guess, for RN to EN to AIN within that.

MR MUSTON: So there is a minimum number of registered nurses per patient which is part of the ratio --

MS CROSS: Yes.

MR MUSTON: -- or per patient population.

MS CROSS: Yes.

MR MUSTON: Then there is a maximum number of assistants in nursing per unit or per patient; is that correct?

MS CROSS: Yes, correct, yes.

MR MUSTON: Perhaps, Mr Whaites, you could explain that to

us.

MR WHAITES: If I could assist, the ratio broadly referred to is one to four in the acute adult medical surgical wards, and within that one to four is an 80 per cent registered nurse requirement. So if you need to have eight on a morning shift, then 80 per cent of those need to be registered nurses. It generally means that one or two of those positions can be either an assistant in nursing or an enrolled nurse.

The final component is that our position was that assistants in nursing ought to be supernumerary, and if I may, I'll come back to that later. So the number of AINs from our preferred position is as many as they want to put on, but the evidence is clear that you need 80 per cent RNs in order to get that patient care benefit, out of the literature. So what we have is a maximum of one AIN per shift on the morning and evening shift in those acute A, Bs and some of the C hospitals. So that's the ratio. One to four, 80 per cent is RN. Of the remaining balance, a maximum of one AIN on per shift.

MR MUSTON: So if you had 10 nurses required to staff a particular unit, eight of them would have to be registered nurses under the ratios and then there could be one AIN and one enrolled nurse?

MR WHAITES: Yes.

MR MUSTON: Would there be a problem, at least from your point of view, Mr Whaites, with the idea that if you had 10 of them, you could employ eight registered nurses, one enrolled nurse and one assistant in nursing, and perhaps then add an extra assistant in nursing so the total workforce is 11, but you have got more than your one assistant in nursing? Would that be problematic or would that not be problematic?

MR WHAITES: No, because it would be above and beyond the ratio. So they are minimums, not maximums; they don't prevent.

Obviously we have a vested interest in growing the nursing workforce for a whole range of reasons. The premise that we've got to have more AINs on shift as part of those numbers in order to grow the pipeline, the logic

starts to speak against itself, in my mind, because what we know is that hospital budgets will be set, they will be set to employ against that level - they are now.

We already have managers that talk to us about the fact that they've got people applying, registered nurses, applying to work in smaller hospitals, but because there is an EN budget line they're not allowed to employ that nurse, that mightn't be a position of the ministry but it's certainly what happens on the ground.

So to have multiple quarantined AIN positions on roster lines in order to grow the registered nurse position when the budget won't fit, you are not growing the registered nurse because you are just creating more AIN positions.

I think one of the other fundamental concerns for us is that the more you dilute the skill mix, the greater the workload on the registered nurses, because of the added responsibility that they have to take.

When we look at, in particular, midwifery, the burnout that is expressed by our members is partly because they are working short but partly because of the additional loads they have to take on with a junior or low-skill-mix workforce. So it is not an automatic fix that having more AINs in the system will grow us more RNs.

THE COMMISSIONER: Ms Dominish, you wanted to add something?

MS DOMINISH: Yes, I just wanted to add something to this. My expertise is more around models and scopes of practice and looking at the services as a whole.

I suppose one of the comments I would make is perhaps one of the limitations - and I respect the position of the association and their objectives - in terms of the way we provide services is not through a uni-discipline. So we do not just provide healthcare services through the nursing workforce. There are always other clinicians and professionals that complement and support the care of patients in a variety of settings, and there will be things that will occur over time which change the way that care is delivered due to advances in technology or treatments or skills of other professions.

But within the nursing workforce itself - and if we look at the pipeline - my understanding is, and correct me if I'm wrong, that the ratios that are set for the RNs don't include other RNs that may be available to support junior workforce and/or students, such as clinical nurse educators, clinical nurse consultants, nurse practitioners, and that's within nursing, and understanding those individuals do have specific roles and functions that they undertake, but it's not just about the registered nurses pure; there's a lot of other things that are going on around that.

I think there is concern, you know, from the changes that we're moving into where, if there's a maldistribution issue and we can't recruit to those set ratios, and there's potentially consequences for districts around the agreements that have been reached from an industrial perspective, then what do we do, because we still have to keep the lights on and operate the services. Whilst there might be an ideal situation to do that, that's not always going to be possible, particularly in our rural and remote environments and where we have challenges recruiting. So that is just what I would like to add to the conversation.

MR MUSTON: Could I ask you, Professor Baird - we might come back to the potential value of assistants in nursing from a workforce pipeline point of view and the way in which training pathways and workforce pathways might overlap - do you have a view on the issue that we've been discussing around ratios informed by your experience? And if you don't, you are welcome to say that.

PROFESSOR BAIRD: Thank you. I would defer to the expertise around the table, but certainly whatever decisions we make should be around patient safety, employee safety, so yes, I agree ratios are really important but we have to deliver a service. But I'm not working in that particular field, so I'm going to defer to the other experts around the table.

MR MUSTON: Can I throw this question out to all of you and any of you can answer. Is there a need to include those sorts of ratios as part of an industrial arrangement as opposed to the decisions around the operation of individual facilities and, if so, why?

MR WHAITES: We think it's absolutely essential that they are in an industrial agreement in order to provide the community the transparency, but for us it's about the accountability and the enforceability. Our experience is that whenever a hospital or an LHD is required to trim their budget, nursing, being the largest workforce, is often an easy target.

We know that compliance with existing award provisions is not always enforced and we have countless stories of our members referring up dangerous staffing levels to their managers and being given very short-change answers around, "Well, that's all there is, you'll just have to cope." We don't believe that that is the standard that the community expects and it's not a standard that keeps our members safe professionally.

Often when there are adverse events on the wards, it is our members that end up in front of the coroners, it is our members that end up being questioned and our members that face possible restrictions on their registration, which can be a product of short staffing and not being able to get things resolved.

So from our perspective, it is absolutely crucial that minimum staffing levels be in an award and that they be enforceable, so that for both our members, but for the broader community, there is accountability and transparency in provision of best practice. Again, I go back to the literature that says that ratios improve morbidity and mortality and are more cost effective.

MR MUSTON: What about the proposition that Ms Dominish raised, that in some facilities it's not practically possible to actually secure and retain workforce consistently within a particular fixed ratio? I will come the ministry about this in a minute, but, Mr Whaites, what's your response to that or how should that situation be addressed if and when it arises?

MR WHAITES: There is evidence, a number of reports again, if you look at midwifery, there was the recent FUSCHIA report out of La Trobe University that spoke about the reasons why people are leaving the industry, members are leaving the industry, nurses and midwives leaving the industry or reducing their hours, and it's because of - well, in the FUCHSIA report, it was workloads, the level of

respect they receive, and certainly our members are clear that the level of pay is not sufficient to make them feel valued. So there's a lot of work to be done to improve the working conditions for nurses and midwives that will help them both with recruitment and to help them stay in those areas.

Yes, there are other classifications of nurses. We note that the proportion of CNEs is dropping rather than increasing. And of course there are other classifications of workers that are in hospitals and we warmly embrace there being more of those as well. Our wicket is nursing and midwifery and that's what we seek to ensure we have minimum staffing levels for.

MR MUSTON: Going back to my question, though, do you have a solution to a situation where it proves impossible to secure sufficient nurses to meet the existing - or do you have a solution to a scenario where insufficient nurses to meet a particular ratio could be secured in, say, a small rural facility? How does one deal with that if it is part of an industrial award?

MR WHAITES: Part of the industrial agreement, although it is not written yet the agreement is there - where there is ongoing demonstrated difficulty in recruiting to those vacancies, we, of course, will go into discussions with the ministry about alternate workforces until such time as recruitment can be improved. So it's certainly not a barrier and you certainly won't see any wards or units or hospitals shut down.

THE COMMISSIONER: So the way I should understand your answer to Mr Muston's question, the first part of your answer I think was there is a whole lot of things that could be improved, and I'm not suggesting this is the only one but I can still hear "pay" in my head, and that might be a means of improving attraction and retention, but if the world was perfect and there was still a recruitment problem or a problem with staffing, then you go into negotiations?

MR WHAITES: Yes. So the proposed award clauses, the framework that we have agreement around is where there is a demonstrated inability to recruit to those numbers, then we will agree an alternate ratio, we'll agree alternate models.

MR MUSTON: Can I just ask in relation to that, in terms of a demonstrated inability to recruit, where does premium labour sit within that as a concept? Is it the position of your organisation that a position which can't be filled by a permanent workforce but could potentially be filled by very expensive premium labour agency workforce is one which cannot be recruited to or can be recruited to?

MR WHAITES: No, if there's premium labour available to fill that spot, then it's available to fill that spot. It's where there is an inability to either use agency or recruit. So where there is an absolute vacancy.

We preference permanent employment. We know that our members are being burnt out with the current levels of overtime and we recognise that reliance on agency is not an efficient model of staffing. At the moment, the levels that the agencies are paying are having very strong pull factor amongst the permanent members elsewhere.

MR MUSTON: Do the ratios and applying the ratios to the extent that they're capable of being satisfied through the use of premium labour, contribute to that pull factor - that is to say, have the effect of dragging people away from the permanent nursing workforce into agency work because it's more flexible, more lucrative?

MR WHAITES: The approach to the introduction of ratios is a staggered one, so the hospitals have time to recruit to get to the numbers and the hospitals have time to look at how they might approach that recruitment. We don't require them to fill the increased FTE immediately.

When we look at the adult medical surgical wards as an example, the enhancement that the introduction of ratios will bring to those sites is minimal. Under the current staffing arrangement they're already at an equivalent of one to four. It's really a handful of second in charge of shift positions - so one additional FTE on an evening shift - in most facilities that you will see that enhancement. So that ought not be a massive recruitment problem for the ministry. We acknowledge that the staffing enhancements within the emergency departments is going to be a significant increase.

MR MUSTON: And that presumably extends to emergency

departments not just in the metropolitan areas but wherever there might be an emergency department including, say, a small MPS with an emergency department on the site; is that right?

MR WHAITES: No impact on the MPSs at this stage. Again our claim is only for a minimum of three on every shift, two of whom should be registered nurses. We are yet to agree what the ratio will be for the level 2 emergency departments in the community hospitals as opposed to the MPSs.

MR MUSTON: Ms Cross or Ms Dominish, did you want to contribute to or respond to that discussion around ratios in particular?

MS CROSS: I just want to respond, I suppose, to some of the statements before. I think everybody in the health system endeavours ever day to make sure that we are providing safe, quality care and we get the right skill mix and we're able to deliver that with the right work mix as well. Sometimes there are shortages and we do need to look at alternate ways of doing that. I guess, I just wanted to make that clear after some of the statements from Mr Whaites.

MR MUSTON: Can I ask you a question about that: is it the case that there are different views about what does amount to safe care in terms of ratios and workforce mix? We've heard from Mr Whaites that there is research that supports the proposition that the ratios being advanced provide safe care, provide long-term savings within the health budget and the like, but is that contested ground, the question around what the ideal mix is or what a safe mix is?

MS CROSS: Look, it's a really complex area and there is research for everything that you want to have a look at. I think, too, the clinical settings, the mix of patients that we have, the care needs that are required are so diverse as well, and you know, we really do need to also include there the nursing expertise and decision-making that's made around how we deliver that care. That means how we come together as a nursing team, along with our other healthcare professionals as well, escalation pathways are there, if there are concerns around what the staffing levels might look like or the acuity of the patients that

we're caring for as well. So it's relatively nuanced and really complex at times, and it moves. I think this is about the flexibility as well.

MR MUSTON: Can I ask, Mr Whaites, do you agree that it's dynamic and varies depending on the particular setting - that is to say, what amounts to safe care in terms of the workforce mix?

MR WHAITES: It does, which is why we don't have one ratio for every setting. Again, there is decades of research to show the benefits of nurse to patient ratios, the minimum of 80 per cent registered nurses for acute medical surgical wards, which is where we're seeking to have that applied. The variation occurs, absolutely. There is nothing preventing the employer from providing a greater skill mix or more staff. In fact, we know when patients require specialty, so one nurse per patient for a period of time due to a number of reasons, that hospitals will provide that additional staffing level. And we agree, it should be flexible, but the lived experience of our members is that the flexibility tends to run one way and the number of shifts that they work short or with low and what we would say is an inadequate skill mix is too common.

MR MUSTON: Do you accept that there is variation in views expressed in research about what amounts to a safe skill mix? You have referred a number of times to decades of research that point to, say, your 80 per cent registered nursing workforce being ideal. Do you accept that there is, as I think Ms Cross has suggested, research that could be called upon to say different ratios or different mixes of RN/EN/AIN medical workforce can provide safe outcomes?

MR WHAITES: Yes, there are articles that will call into question the evidence of other pieces of research. I'm not aware that there has been a competent review of meta-analysis of all of the research put together. I've read some pieces that have attempted to do that and they say that, on the balance, nurse to patient ratios are cost effective and do have benefit for the patient outcomes.

We know that the recent introduction of ratios, for instance, up in Queensland was monitored and it found the same things. The hospitals where the ratios were introduced performed better over some of those metrics than the hospitals where the ratios weren't implemented. So

recent evidence suggests we're on the right path.

MR MUSTON: Could I move away from ratios and perhaps we will come back to the scope of practice question, which is important and probably related, but can I just turn to you, Mr Griffiths, and ask from the point of view of the nursing and midwifery workforce, what workforce data is available and collected by the ministry?

MR GRIFFITHS: There's quite a comprehensive set of data available. So basically the fact that we run one payroll across NSW Health, any paid hour, you can generate a report on. So we look at head count, we look at the full-time equivalent workforce from that head count, we look at overtime - overtime as a proportion of the total paid hours - the use of agency and the patterns in terms of where those agency nurses are being deployed to, demographic data in terms of age profiles and gender, et cetera.

So the fact that we've got this central visibility over most of the data allows us to have a pretty clear understanding of what the workforce is and what it's doing. There are some limitations that we've talked about before where systems don't talk and where certain information isn't available, which is challenging, but we can usually then look at other ways of getting an understanding of that data anyway.

MR MUSTON: So dealing with the shortages and maldistribution, do you have visibility of where within the system those shortages exist - that is to say, where there is immediate need within the nursing and midwifery workforce across the system?

MR GRIFFITHS: So we certainly have a picture of where we're utilising alternate workforces like agency employees.

MR MUSTON: Pausing there, the agency workforce does have a natural place within a system in terms of filling leave positions and people who fall unwell and are not able to go to work at short notice and the like. Would that be right?

MR GRIFFITHS: That's right.

MR MUSTON: And so to the extent that the visibility of the agency utilisation within particular areas - what is it

that you look to to identify whether that is more than just its natural place, it's instead becoming a part of the permanent workforce or it's filling a gap in the permanent workforce in a way it ought not ideally be.

MR GRIFFITHS: Yes, and look, data isn't the only source of that information. As a networked health service, we maintain, pretty close contacts with the directors of nursing in those organisations and the directors of people and culture. So we have a fair understanding around our areas of challenge.

MR MUSTON: How does that information feed into the work that your group does - that is, the relationship with the directors of nursing, and the like the on-the-ground experience of workforce shortages?

MR GRIFFITHS: We get a very clear message from them around where their pain points are. If I think about a recent initiative, our organisation entered into a statewide contract with nursing agencies because we heard of pain points around the availability of price in terms of nursing agencies. That was playing out differently in different local health districts. Some prices were fairly elevated in local health districts and others weren't as impacted.

So the conversation with the directors of nursing and the directors of people and culture related to the fact that they can't - that there is a different experience across the state, and that budgets are much more universal in terms of the way that we formulate a budget for a district. So we negotiated a statewide contract which is bringing, and will continue to bring, prices down in terms of the cost of agency workforce.

MR MUSTON: Ms Dominish, I think you were gesturing that you might have wanted to add something there.

MS DOMINISH: I would add a couple of things to Richard's comments.

In the previous hearings I gave evidence about the workforce modelling that we undertake and, as Richard said, we gather information on a regular basis from a variety of sources, and the district directors of nursing and midwifery are one of those. However, the work of the

modelling team which we've just referred to, that has told us we've got the shortages in midwifery, enrolled nursing, but a steady supply in registered nursing at a state level, we're now undertaking work district by district where we're doing modelling on a district-by-district basis in partnership with the Nursing and Midwifery Office and the directors of nursing and midwifery and other people in the district, like finance managers, clinicians, to unpack the qualitative information about what's actually going on in that context. That will then feed into the modelling that's done for those individual districts. So that's happening over the next 18 months because it takes time to go through each one.

I was going to make another point and I've lost my train of thought I think. Oh, that was the other thing. In terms of responsiveness to where we can see there's a significant issue, the minister just announced an initiative to bump up the incentive bonus for midwifes for areas of MM3 to MM7, so that's an immediate response where we've seen there's an urgent need to do something while we're trying to work on the pipeline issues, which is going to take some time.

THE COMMISSIONER: Is this the $20,000?

MS DOMINISH: Correct. It's been bumped up from 10 to 20; is that right?

MR GRIFFITHS: Yes, it's 20,000 now for all midwives in MM3 to MM7 locations. So we haven't scaled it. We've used it as a sign-up bonus.

MR MUSTON: Just to try to understand it a bit better, the data that you have currently, that is before you finish this 18-month program, does it currently tell you where there are immediate needs for nursing and midwifery workforce of particular types, enrolled nurse, registered nurse and midwives? That is to say, would you know if there was a particular need in a particular facility in, say, Brewarrina, hypothetically?

MS DOMINISH: That would usually come to us, and I will defer to Jacqui and Richard, through that relationship and the qualitative discussions we're having around the nuances of what's going on in specific sites. I don't know if we monitor it down to the facility level currently but I might

let Richard and Jacqui speak to that.

MR GRIFFITHS: Certainly the modelling - the 18-month exercise is designed to give us that visibility by local health district around what their pipeline is looking like and modelled through to 2040.

In terms of facility visibility, we have that, but again, it's a snapshot of the overall workforce at that facility. It's not the vacancy data per facility. So we can see per facility the paid hours, so what the full-time equivalent nursing workforce looks like at that facility. That is assuming, as well, that they have their cost associated with the facility. That's not necessarily the same across all districts. But we have a fairly clear snapshot by facility on some of that cost data - so what we've paid out in terms of base hours, overtime hours, agency.

MR MUSTON: Does that give you an indication, based on an understanding of the facility, of whether there are shortages, workforce shortages within that facility?

MR GRIFFITHS: It does, you can see a reliance on agency, for example. But to be honest, we don't need the data for that. Our organisation is distributed and there are leadership teams at those organisations who escalate that through their local health district. So the local health district director of nursing has a really good understanding generally of the nursing challenges at each of those facilities across the local health district.

MR MUSTON: Putting the data to one side, is there a central repository of that information that comes in via those other sources? For example, the workforce team on the ground in Western New South Wales saying, I'm not meaning to pick on it, but hypothetically, "We are really struggling to fill nursing positions in Brewarrina. Here's the number of people who we need", is there some central repository of that information, that less data-driven information?

MR GRIFFITHS: Not as such, unless, Ms Cross, you are aware.

MS CROSS: No.

MR GRIFFITHS: Certainly we've got a pretty good handle now on hard to fill and critical vacancies across the district. When a local health district declares a role is a critical vacancy, we keep a central register in the ministry so we can monitor some of those trends to see if there's something we need to do from a policy perspective. So we're definitely getting that sort of snapshot for the rural local health districts.

Metro is a different story. That is really more the local health district that has more of a handle on its supply challenges.

I don't want to speak in generalisations, but Sydney is relatively well supplied in terms of the nursing workforce. Our challenge really is those outlying areas. So even the outlying areas of Sydney are relatively challenged. So anything sort of MM2 onwards are the areas where we see more recruitment challenge. That's not necessarily to say that there aren't some specialties that are short, and we definitely have some challenges in terms of supply for some of those nursing specialties.

THE COMMISSIONER: When you say "Sydney is relatively well supplied in terms of nursing workforce", does that include midwives?

MR GRIFFITHS: Not midwives. Midwives is universally problematic.

THE COMMISSIONER: Can I just ask you something about that so that I understand it: do you have your statement?

MR GRIFFITHS: I do.

THE COMMISSIONER: The recent one, paragraph 31, just so I understand all that you're conveying here. So in 30 you tell me that the numbers of midwives graduating and projected to graduate are falling behind demand. Then you talk about Australia and internationally and the work currently being undertaken, and then you tell me that in New South Wales the midwifery shortage is as a result of an ageing workforce, and I can understand that, there are a lot of people heading towards retirement or retiring; reduction in worked hours - why is there a reduction in worked hours?

MR GRIFFITHS: There is a propensity for people to both work part time, as opposed to choosing to work full time --

THE COMMISSIONER: This is the choice of the midwife, then, to work less hours?

MR GRIFFITHS: Yes. By choice, correct

MS CROSS: Richard, there's maternity leave as well for the midwives, that's part of that - returning to work part time. It's a younger workforce and it's predominantly female.

THE COMMISSIONER: Then there's "accessibility to training programs in regional and rural areas". I take that to mean a lack of accessibility, is it?

MR GRIFFITHS: Yes, it is a challenge, yes.

THE COMMISSIONER: And "the maldistribution of employees across metro and regional areas", then "increased complexity of maternity care needs". What should I understand that to mean?

MR GRIFFITHS: There is a desire for more experienced midwives in maternity units.

THE COMMISSIONER: From the patients?

MR GRIFFITHS: No, from hospitals.

THE COMMISSIONER: From the hospitals. Okay.

MR GRIFFITHS: Yes.

MS DOMINISH: Could I just add something to that around the complexity?

THE COMMISSIONER: Yes, of course.

MS DOMINISH: Zooming out to look at the context in the state, so particularly in our rural and remote areas we have difficulties with GPs and GP obstetricians, and so if you're looking at maternity services and the role of midwives, there's pressure on junior doctors and on GPs to provide those services particularly in areas where there are not many people around, as in clinicians and then --

MR MUSTON: Pausing there, when you say you have difficulties with GPs and GP obstetricians, I assume you mean difficulty getting them?

MS DOMINISH: Yes, they are in decline, and the GP obstetricians --

THE COMMISSIONER: This leads to the importance of midwifery models of care, maternity services?

MS DOMINISH: Correct. Because whilst we have incredible midwives that provide leadership in those midwifery group practice models, there are always going to be circumstances where you have to have access to a doctor, to an obstetrician, and the knock-on effects we're seeing in general practice obstetrics, junior doctors wanting to work in rural areas to become obstetricians or to become rural generalists, when you put that whole picture together, trying encourage people to be midwives and midwives in rural areas, it adds another layer of stress and complexity and a challenge for districts to keep those services open.

MR MUSTON: I will come to you in a moment, Ms Cross. I think Mr Whaites has been patiently waiting.

MR WHAITES: Just a couple of things very quickly. We note that the ministry has been renegotiating the agency fees. Our concern is, in the absence of another workforce available, it's merely going to mean that people won't take up those agency shifts and relocate. We appreciate the push and pull that that's creating but you can't just take away that workforce without having a plan, and we say that plan is better wages to attract people there in the first place.

When you look at the request for more senior midwives, absolutely, our data - sorry, it is the Ministry of Health's data, we GIPAA the ministry on a regular basis - what we see is since 2016 to now, there's been over a 10 per cent, I think it is getting closer to a 12 per cent reduction in the number of senior midwives that are working in the system. So that's not about people retiring, because you would imagine that people age, they move up the scales automatically, it means that they are not retaining the midwives in order to become senior midwives. There's a problem there.

Again, I come back to the FUCHSIA report in Victoria. They talk about exactly the same conundrum. When they interviewed their cohort within that research dataset, the overwhelming feedback was workload, pay and lack of respect in the workplace. This is what is driving midwives to either leave the industry or reduce their hours, and in fact the FUCHSIA report showed that for 1 FTE you need 1.7 actual people now to fill that FTE. So midwifery does need some special attention.

I think also we've got data there --

THE COMMISSIONER: Sorry, can I just ask you to pause there. I understand pay.

MR WHAITES: Yes.

THE COMMISSIONER: Workload means specifically what, when you're talking about that as a problem?

MR WHAITES: So one example of that is the number of midwives on a postnatal ward, particularly with the increasing intervention rate, increasing numbers of caesarean sections, when you have inadequate numbers of midwives on a shift then, you know, that's an unreasonable workload. So that's an example of that.

THE COMMISSIONER: And lack of respect I understand generally, but where is the lack of respect coming from?

MR WHAITES: Our members talk about a general lack of respect either from within their workplace or how they are perceived within the system. So if I go large scale for you and we talk about solutions, absolutely agree, the call for midwifery-led models of care and greater utilisation of that we strongly support. It is an easy and identifiable solution. All of the evidence shows that such models of care provide better outcomes, the women rate them more effectively and they are - unfortunately, our midwives are not paid the same rate as an obstetrician, so they are therefore more affordable. There are barriers to those being established and that's around the autonomy of those midwifery-led models of care, but we think that there is a great opportunity for some pilot models to be run.

THE COMMISSIONER: Let me ask you a different question.

Is the lack of respect that you are talking about more isolated examples than systemic or do you think it's systemic?

MR WHAITES: I think on one level it's systemic. The barriers to having midwifery-led models of care and the perceptions of others that midwives can't possibly take total case responsibility --

THE COMMISSIONER: It's lack of respect for the skills, is it?

MR WHAITES: Yes, and I think there is an increasing - so midwifery-led models of care are typically applied for low-risk populations, but when you look at what will put a woman into a high-risk category, midwives are still more than able to look after that cohort of women as well. So some movement around the definitions of which high-risk women midwives can look after, what referral processes we have in place to make sure that it is safe and what urgent transport services we have available also - there's a lot to look at there but there is some great potential.

THE COMMISSIONER: All right. Did anyone want to respond to anything Mr Whaites just said in those last answers? All of you should feel free to just chip in when you need to.

MS CROSS: I think I might have presented this in my previous round of evidence, but certainly from our office's point of view we have had a very strong focus on the midwifery workforce and engaging with all levels, and we have presented the work to Mr Whaites as well, really going to that cultural piece, so growing the midwives on the floor, supporting those workplace cultures through various programs that we've got in place, a very successful mentoring program and an adaption of tools around how midwives actually engage with each other; communities of practice so that we're able to support the midwives on the ground to advocate and lead the development of midwifery-led models of care, and one of those has been one of the alternatives to the midwifery group practice - it is not meant to replace it but it is part of the suite - and that is the MAPS model that we have spoken about, so the antenatal/postnatal, so it is a form of continuity of care. We're seeing that really develop quite strongly across the state. And not just because of the model but because we're

supporting the midwives to actually engage and to advocate for those models of care as well. So we're giving them skills to do that.

Another piece of work that we've just finalised is we have been looking at actually how we support midwives in their practice. So we've developed a sort of central portal, which we're calling the "Midwifery pathways of practice", to actually access that skill. Again that's twofold: that's actually to tell the system that we believe our midwives can be doing the sort of clinical procedures and the like as well, and supporting them to do it. So there is a whole suite of work happening.

I guess on to the point of a more junior workforce, we are investing heavily in the student midwifery workforce because that's our way of growing midwives as well, so how we support the midwives to gain skills.

THE COMMISSIONER: Can I ask a follow-up on that to Mr Griffiths. Going back to your statement, in 33 you said, in relation to the Bachelor of Midwifery, "our workforce modelling has identified an undersupply". What should I understand to be the extent of the undersupply?

MR GRIFFITHS: Well, I don't have that in front of me, Commissioner, but --

THE COMMISSIONER: You can take it on notice, but just a general sense? How big is it? How big is the problem?

MR GRIFFITHS: I will take it on notice. Look, in terms of the size of the problem, essentially what that means is our university graduates aren't keeping up with the demand in service.

But the other thing I was going to add, and Ms Cross sort of alluded to it --

THE COMMISSIONER: That doesn't have to amount to much to become a significant problem.

MR GRIFFITHS: No. But I did want to just say as well, in New South Wales - I meet very regularly with my counterparts in other states and one of the things that regularly comes out of those meetings is that for New South Wales, we're a little envied in terms of the fact we've got

two pipelines.

The other states are relying on the bachelor program. Our MidStart program is really giving us an alternate supply. In fact, I have put in my statement at the moment it is a stronger supply than the bachelor program. It is a program that provides us with an experienced registered nurse, so we don't have that level of immediate career-starter status, when you get someone straight out of university. So while it is a challenge, some of the other states are a little envious that we have continued with our MidStart, and that is helping us. I think the problem would have been more significant had we done what the other states have done and closed off that as the training pipeline.

THE COMMISSIONER: Should I take from that also that where you say in 31 there is a recognised shortage of midwives across Australia, the undersupply in New South Wales is in percentage terms not really significantly different to any other state?

MR GRIFFITHS: It is not. Yes.

MS CROSS: Can I just add, too, just on the point around being mid pathway, again, we're doing a big body of work to actually increase the number of student midwives coming through that pathway. So we have got data to show that that hasn't met what we've required. So we've actually got quite close with the districts to increase those numbers --

THE COMMISSIONER: I should know this, but MidStart, when did that start as a means of - approximately.

MR WHAITES: MidStart preceded the bachelor of midwifery. It was how I became a midwife, a registered nurse first and then a midwife. Can I just comment --

THE COMMISSIONER: Of course.

MR WHAITES: The data we've seen and is within the rapid business case, which was also a submission to this Inquiry, shows that New South Wales consistently has a higher number of midwives in New South Wales who are not working in midwifery.

THE COMMISSIONER: The rapid business case, is that to do

with the award?

MR WHAITES: That's the Deloitte - yes.

MR GRIFFITHS: We need you back on the floor, Michael.

MR WHAITES: New South Wales consistently has a higher number of people who are qualified, have a current registration to work as a midwife, who are not working in the industry.

I'm also a little trapped, because I sit on the national AMF midwifery body and was fortunate enough to represent the AMF at the "Midwifery Futures" project on the working advisory group. That report comes out on the 23rd, so very soon.

THE COMMISSIONER: Of this month?

MR WHAITES: Yes. I had to sign a confidentiality agreement as part of sitting on that.

THE COMMISSIONER: We can't ask you about the recommendations, then, can we? Well, maybe we can, but we won't.

MR WHAITES: No, but they would be useful to this hearing, to this Inquiry.

THE COMMISSIONER: It is only a few days.

MR WHAITES: Yes. So I think then, setting all of that aside, what we need to look at is how we retain the current midwifery workforce, how we encourage the current midwifery workforce to increase their hours. That's our best bet for - that's what you see out of the FUCHSIA report, that if you improve wages, if you improve working conditions and you improve the respect at work, you are going to end up with a workforce --

THE COMMISSIONER: I won't ask you whether they are possibly in the recommendations that have been made, but it's not impossible, I suppose.

MR WHAITES: I'd take you to the FUCHSIA report then.

THE COMMISSIONER: Of course, yes.

MS DOMINISH: Could I make a comment just with regards to respect? I was going to just add that before.

THE COMMISSIONER: Yes, please.

MS DOMINISH: I partially disagree with what Michael has said around respect, or I acknowledge where that is coming from, because from my experience working across the professions, and particularly with medical and our rural GPs and obstetricians and others, I think there is absolutely respect for midwives and what they can do and deliver, and so I don't think it is systemic. I do think there are issues in particular locations.

Part of it is not necessarily - like, there definitely will be issues around respect, but it's understanding what is the role and scope of the midwife and what are they capable of, and when clinicians, other clinicians, don't understand that, they shut down and they create barriers.

So the focus of NSW Health, and the stuff that Jacqui Cross has just talked about, is around the other work we need to do with the clinicians and with the services that work in partnership with midwifery to raise the profile and increase the education and understanding of their role and their capability and what value they can add to the system.

THE COMMISSIONER: I think we had an example of a midwifery model of care being discussed at a roundtable in Tamworth and that seemed to be well supported by the LHD but also by the medical people.

MS DOMINISH: Absolutely, they're a lifeline to them.

THE COMMISSIONER: That's one example, I'm not suggesting that ones that aren't as positive as that, but that was one positive one that we heard something from about.

MR MUSTON: I was about to ask Professor Baird to tell us about the midwifery pipeline at its source but I am mindful of the fact that it's 11.27.

THE COMMISSIONER: Can I just quickly tick off what I wanted to ask Mr Griffiths about paragraph 33 before we have a break. We talked about undersupply. Then you tell

me about the contributing factors. One is the availability of clinical placements - and let's just worry about LHDs. So a lack of clinical placements - why?

MR GRIFFITHS: There's a couple of reasons. One is that to get the number of graduates there's a bit of a catch-up period for the bachelor program, which means that we probably need to have more students in place than what we've historically had, and there's work that we need to do from the ministry with the health system around the burden that students present - well, the opportunities those students present to the health system, but there is --

THE COMMISSIONER: Is it a funding thing?

MR GRIFFITHS: No, it's a capacity issue.

THE COMMISSIONER: Right, I see.

MR GRIFFITHS: It relates to the supervision of those students. But there are things that we can do there to work through the way that we manage student placements with the health system, plus also with our university partners, and I can see Ms Cross is keen to contribute.

MS CROSS: I guess that's the work I was just talking about before. One of the sort of fundamental pieces that we've been doing is the mentoring piece. That was supporting our current midwives to support the student midwives and the future midwives, but also, I guess, working with the managers of those services as well, so they can actually understand what - well, not understand but actually further understand what the throughput is, the complexity that they've got, the current staffing levels that they have, what would occur if they continue with the student numbers that they currently have and what their uplift needs to be to actually support them to do that. That's just assisting them to plan, thinking forward around how they're going to get a good workforce into the future.

THE COMMISSIONER: Just finally on 33, you say that the alternative postgraduate pathway - and we've discussed MidStart - has been the stronger pathway. Is there anything you want to expand upon about why you think it has been the stronger pathway or what the evidence reveals?

MR GRIFFITHS: In terms of the strength of the pathway

I was really referring to the proportion of MidStart versus the bachelor program is higher, so we get more through MidStart at the moment.

THE COMMISSIONER: It is just a numbers thing?

MR GRIFFITHS: Yes - well, yes, but there is also the value of having an experienced registered nurse working in that pathway.

But, Commissioner, I know that I was focusing on LHD capacity, but, you know, if you were looking at broader solutions to this program, there really is an opportunity for the system to come together with private hospitals around capacity, because there is a healthy maternity private market, and if we're really serious about increasing the number of graduates, then we both need to be at the table looking at capacity and supporting those students.

It's beneficial for students to get experience across both, because you come into the public system --

THE COMMISSIONER: And that doesn't happen?

MR GRIFFITHS: It's siloed. Yes.

THE COMMISSIONER: All right.

MR MUSTON: We might explore that after morning tea.

THE COMMISSIONER: All right. We'll take a break until 11.50. We'll adjourn until then. Thank you.

SHORT ADJOURNMENT

THE COMMISSIONER: When you are ready.

MR MUSTON: I will just give everyone a moment to get settled.

THE COMMISSIONER: Sure.

MR MUSTON: Professor Baird, I was going to turn to you now to ask you some questions about that workforce pipeline, and perhaps if we start with midwifery, given it's the topic that we've been addressing. What does that

workforce pipeline look like from your perspective as an educator of undergraduate students?

PROFESSOR BAIRD: Thank you for that question. I would just like to say I'm actually one of the key researchers involved with the "Midwifery Futures" project, and that actually came from the Burnett Institute with UTS. I will seek permission to see if I can share that report with the Commission. It is due to be released on 23 October.

THE COMMISSIONER: Thank you.

PROFESSOR BAIRD: I think it would be really helpful in terms of modelling of each state, and it clearly shows the number of predicted future midwives that New South Wales may need to account for the shortages. So I just wanted to say that.

Clearly we have a shortage of midwives and I can only speak from the perspective of a higher education institute like UTS, and also around - we do run the two programs, as Richard has said, the MidStart graduate diploma of midwifery and also the bachelor of midwifery program.

All I know with the bachelor of midwifery program, it is so highly subscribed to, our ATAR sits at 97 for entry into our program. We do have other pathways that UTS supports for our Aboriginal and Torres Strait Islanders and students from low socioeconomic backgrounds, so we can have a pathway to support them, because clearly what the data also shows from the "Midwifery Futures" report is that we don't have enough Aboriginal and Torres Strait Islander midwives coming into the profession.

So if I can give you an example, we had over 700 applicants for 80 bachelor of midwifery places last year. So the course is very popular, but we are constrained by how many placements we can offer the students that we have.

I do want to acknowledge the ministry and Jacqui Cross. Particularly, since I moved into the role, we've increased the midwifery placements by 20 per cent. If there's opportunity to expand them to more, we could certainly do that, but not without the clinical placements to support the students.

MR MUSTON: So what are the limiting factors? You said

you had a huge number of applicants for a relatively small number of positions. In the context of a section of the workforce which sounds like it's in desperate need and an area, a workforce area where a graduate could presumably walk into a job within the public health system, what is it that constrains the number of places that you are able to offer students who wish to study in this area? You have touched on clinical placements. Is there anything else?

PROFESSOR BAIRD: With the MidStart program, we don't have to source those clinical places. I'm very grateful to the ministry. The ministry actually sources those places for us. So we have to find placements for the bachelor of midwifery students, and that is very much relationship based. We have to source those placements ourselves, and we've built up very good relationships with many of our local health districts and our nursing and midwifery directors. But we have several universities that are also looking for clinical places for their students, too. So those relationships are integral to securing our program. So I would say it is very much relationship-based, university with the local health district, the nursing and the midwifery director.

I mean, we've been fortunate, we've been able to increase the places with the support of the ministry, but sometimes it feels that we could do a little bit more in terms of sourcing some more clinical placements around looking at how our students are supported in the clinical placement, because obviously we wouldn't put students into a clinical area if we didn't feel they were being well supported.

MR MUSTON: So is it the availability of clinical placements which is the key cap on your ability to train more midwives through your institution, or are there other limiting factors that come into play?

PROFESSOR BAIRD: I think the main one is the availability of clinical placements definitely, but there are other factors that may make it challenging for students in terms of travel, in terms of funding. We're delighted that, you know, we now have the award coming for student nurses and midwives that work in clinical practice from '25, I think, mid '25, but that will be means tested. In reality, Sydney is a very expensive place to live, cost of transport, cost of travel, we find that we lose some students and when we

talk to those students it's not because they don't feel supported in clinical environments, it's not because they are not enjoying the course, it is sometimes related to just the cost of living that I think everybody is experiencing at the moment.

If we could even get free travel, free parking - just small changes that perhaps we could look at, but those decisions don't rest with us as an education institute, but certainly those are things that perhaps we could think about in the future.

MR MUSTON: In terms of the impact of the clinical placement on career pathway, do you, viewing it from the perspective of an educator, sort of at entry point, do you have any observations that you have been able to make as to the extent to which placements can impact on the way that people's career progresses at least in the early years? That is to say, do people tend to work where they end up placed?

PROFESSOR BAIRD: Most do, because what we try to do is give students a home base so they feel a sense of belonging, and certainly that is what we've been doing with our assistant in nursing program, with three of the local health districts across Sydney. We're able to offer our nursing students and some of our midwifery students an assistant in nursing placement, and that means that that student nurse or student midwife will, for two years, do all their clinical placements in that local health district, similar to what Jacqui was talking about earlier.

They get a sense of belonging, they get paid, working in the field that they're going to move into when they graduate, and what we've been able to agree with that local health district is that at the end of the two years they will automatically be offered a graduate position into that local health district. So that sense of belonging, that home hospital, I think, supports student nurses and midwives to feel already part of that workforce. So far, with one local health district, this is our second year of running that program and we're doing an evaluation of that and it's been very positive.

MR MUSTON: So that's an arrangement that your institution has brokered with a particular local health district and one particular facility within that local health district

or a range of facilities?

PROFESSOR BAIRD: Really we made that arrangement with the nursing and midwifery director. So if we look at North Sydney, the student could work in several hospitals within that local health district, but they belong - they have a sense of belonging within that local health district which seems to really matter to the student, which I can understand is really important.

MR MUSTON: So if I have understood it correctly, the placements happen through that home base local health district, probably a similar facility for a student who goes through their placements, and then at the end of their studies, assuming they graduate and become registered, they walk into a guaranteed graduate position?

PROFESSOR BAIRD: That's right.

MS CROSS: Can I just make a comment on that?

MR MUSTON: Please do.

MS CROSS: There is a centralised graduate recruitment process, so we do need to be equitable and fair around how people are recruited into those positions as well. They do need to go through the normal process and be employed on merit, because we do have such a large number of nurses graduating or vying for positions as well, so we manage that that way, too, so we have to make sure that there are equal opportunities there.

MR GRIFFITHS: Just one of the other challenges with that is it saturates metro Sydney and it saturates towns that have a university. It's not always possible for Wagga Wagga, for example, to take all of the students that would like to do an AIN program, because we don't have that capacity, and they don't have an alternate hospital close to work in, whereas in metro Sydney you can do that. So it works in Sydney. It won't necessarily work in regional New South Wales.

MR MUSTON: Is there scope for a closer collaboration between the ministry and educational institutions at a central level to occur to try to distribute these student placements in a way that perhaps reflects areas that your data is telling you you have immediate and future need?

MR GRIFFITHS: So you are talking about student placements not the AIN program?

MR MUSTON: Well, start with student placements, yes.

MR GRIFFITHS: At the moment the ministry centrally coordinates and controls capacity. So through ClinConnect we open up capacity for students in the health system every year and then the education sector interface with that system and allocate students to those places and it is a partnership.

Then the arrangement that each of the universities has with the local health districts is under a partnership agreement where they have come to an arrangement around how that student's experience will be managed during that placement.

In terms of your question, yes, there's probably more that we could do in terms of ensuring that there's more capacity, I suppose, but we would need to - there are so many players involved, so it is the ministry, it is HETI, it is 96 education institutions that we deal with. So it could be done but the system that we've got was pulled together to take into account the complexities of the education and health interface.

MR MUSTON: The indication from some of the evidence that we have heard, and it may be wrong, is that of those 96 educational institutions, they each independently are going out to local health districts and trying to broker agreements for the taking of students. Is that effectively the way it works, perhaps under the umbrella of the ClinConnect system, but the extent to which a particular institution can get a number of placements in a particular institution or LHD is dependent upon the relationship that might be forged between that Institution and the LHD?

MR GRIFFITHS: That is true. It does come down to a partnership agreement between the educational institution and the relevant health service. It doesn't necessarily translate to every hospital, it usually translates to a local health district or a collection of local health districts.

So yes, it does mean that they have to have that sort

of relationship, but it's important, because it takes into account the student variation and the student needs during that placement. There is some variation across those agreements because it depends upon the infrastructure at the university, it depends upon the infrastructure of the health system as well in terms of supporting students during that placement, and there will be an arrangement of sorts between the two organisations that takes into account whether they can provide supervision at the local health district or the university needs to step in and provide supervision, and there is an appropriate sort of consideration that is given around that contract.

MR MUSTON: From the perspective of an educational institution vying for spots, Professor Baird, do you have a view on how that system works and whether it could be improved or adjusted by perhaps centralising the process a little bit more and dealing with it in a slightly more coordinated way than the existing arrangement between institutions and local health districts?

PROFESSOR BAIRD: It is really complicated. If I look at UTS, we have over 12,000 students, over 3,000 different sites that we send students to. It's a logistical jigsaw puzzle that we employ a lot of people to help us with. So I think when you look at that across every university, across the whole of New South Wales, it would be an absolute - I wouldn't envy anyone having to do that.

I think there is probably scope to look to see if there are different ways of doing that, but I'm not across - I don't have the expertise that the ministry has to think about what that would look like on a much larger scale. It would certainly take away the need for that relationship-based relationship, but it's how you would do that fairly, as well, and that every university was treated fairly, so I think it would be quite a logistical nightmare but that's not to say it isn't something that could be looked at, and maybe that would allow for the predicting model of how many nurses do we need in five years' time, how many midwives do we need in five years' time?

I can only talk from my experience in the UK where that was very much done at the health district point of view, but that was much smaller than what we're talking about here. And all the other health professions that it would involve around bringing into a hospital, student

paramedics, student physios - it's just huge.

MR GRIFFITHS: I was just going to say that we're very open to looking at the way that we manage student placements and we've started some discussions with deans of another discipline, allied health, around how we can address it. What came to us was some issues in terms of the variation across the agreements. What I've sort of asked as an approach to deal with it is looking at what do we want the student experience to be, because we're not the only organisation in town that should be training students.

So if we're going to reframe the student placement experience, it should relate to the experience of the students, which would mean that the universities would also have to come to the table in terms of the way that the curriculum sets out the expectations of the student placement. That may then need to go to the councils, in terms of accrediting their courses. But I think we need to all come to the table to have the discussion.

We've started that with the allied health deans, but as I said, we're really framing it around student experience, what do we want students to get out of a placement in the health system, with the ultimate outcome being we want a better job-ready graduate that doesn't then need to rely necessarily on a detailed new graduate program; they become more job ready when they leave their course. But it's a massive piece of work and, as I said, a lot of it will be unpicking things that have been in place for a very long time, and so all parties need to be in agreement that it's a way forward, if we're going to do it. I don't know whether anyone would want to talk about the deans of nursing.

MS CROSS: Certainly we've been echoing the same approach in nursing and, Kathleen, you've been part of two workshops that we've had now with our major players, universities, our deans and heads of school. It's very much the approach that Richard is talking about, I think recognising that that preparation as a student is so critical and actually supports them as they come into the healthcare setting as well.

I have to say the group has come together, there is real willingness to look at things a little differently, to share ideas, to think about where that could be scaled

where appropriate. I think Kathleen touched on a few good critical points there in the fact that whatever we do, we have to make sure that things are equitable as well, so individual universities brokering different things, and we want to make sure there is access for all, because the last thing we would want to do is curtail the number of students that we can support in the system as well.

But as Richard said, it really is about that experience and also how do we support our staff on the ground to support the students as well. For us in nursing, it's on the back of the work that we've done with midwifery, so really exploring with our nurses on the floor, I guess, their capability, their confidence in being able to support student nurses as well.

What we found in midwifery was there was a willingness to support the students but they didn't feel that they had the skills or the ability to do that, and as I said before, that's why we've developed the mentoring program.

Midwifery is a nice little tight workforce and we're able to get on the ground and work with them. My experience has been that sometimes we have these programs, mentoring programs, preceptorship programs, whatever we like to call them, we roll them out and they have very mixed success. That real success happens when we're able to work on the ground with the staff, and again I keep coming back to midwifery. We've had five years where we've been able to do that and it is paying dividends now. So it is complicated work. It does require, I think, close support of the workforce on the ground.

MR MUSTON: But a system that allocates placements to different institutions based on individual relationships between LHDs and institutions and the particular deal, for want of a better word, that an institution can bring to an LHD in terms of accommodating students for placements in and of itself has the capacity to produce some inequality, at least between institutions, doesn't it?

MS CROSS: I think when I think about the relationship, to me, it's actually more about the other pieces that fall out of that, so supporting research, the co-joint appointments, if there are some challenges in some particular areas, then they can work that through and pick up the phone. I know Kathleen and I have had one of those conversations.

So that is really critical as well, so where are the touch points in that as well? But coming back to your point about managing clinical placements, that was the premise of ClinConnect as well, about building in some equity that relationships come through the individual agreements, but I think the actual sort of coordination probably happens a bit more distant than that.

MR GRIFFITHS: I've got to say, though, I don't know that the inequity in terms of the arrangements is felt at the student level. I think that's more the organisations, and having looked at the different agreements in place, they sort of net out to be much the same, because there is give and take on both sides that just ensures that we are able to provide that student experience. So yes, there is some variation at times in terms of price; if we're providing the supervision there are some variations in terms of price.

I sort of argued a couple of years ago that we sort of operate in a bit of a free market economy really and they've been able to strike that price through arrangements based on what they can provide and what they can't provide. I know that that does frustrate universities at times and that might be something that we can look at. But the student shouldn't feel the inequity.

I think the issue at the moment is things that are outside our control that would provide a better student experience, as Professor Baird has indicated, things like the student poverty issue that is being raised in different jurisdictions. That prevents good placement in hospitals where we can provide a very good experience for that person but we can't attract because they're too remote, for example. So some of those things would be of benefit to us in terms of improving the overall student experience but we don't have those levers to pull.

MR MUSTON: Is there not scope, though, if the process were more centralised and assessments were able to be made, economic assessments were able to be made, say, of the long-term benefit of placing a cohort of students in a very difficult to fill position in, to use my hypothetical, Brewarrina again, just because it is the one we keep picking on, but that whilst there may be a cost, even to the ministry, of providing a scholarship or funding

the placement of students in that facility, if the long-term benefit of that was you had students who ended up working there and reducing your reliance on premium labour in a facility like that, it may well be that there would be some advantage to the ministry, but that advantage is something that the institutions would be incapable of seeing.

MR GRIFFITHS: Yes. I'm just thinking through that Brewarrina example.

MR MUSTON: It might be a perfectly well staffed facility, but --

MR GRIFFITHS: I know it's a hypothetical but the challenge there is, obviously, whether there's activity and supervision that would provide the experience. That's where we would be relying - in those very hard to fill areas where we're already struggling to attract a workforce, we're probably not going to be able to provide the supervision that would be required. So we would be relying on the university to provide that supervision and paying for it, and they are probably in the same position, where they probably can't provide that supervision at that location as well.

So I'd love to be able to place students in some of those facilities, but there are so many things at the moment that prevent us from doing it.

THE COMMISSIONER: That was a really remote example.

MR MUSTON: It was. Ms Dominish?

MS DOMINISH: Just, I suppose, looking at all the parts connecting together - I can understand the concept of saying, "Let's centralise it" and then we just send people where we need to go, and I think the complexity has been highlighted that that can't be done in a vacuum where the qualitative information about what's going on across the state and where placement capacity is which may change from, you know, month to month or year to year, depending on what's going on with workforces. But in terms of trying to be solution focused, because I've had multiple conversations about this over the years, and reflecting on my experience having worked as an exec director in a district, allied health, is, is there an opportunity for

us, as you've suggested, to possibly tighten up or strengthen the governance at a state level and the formalised relationship between health and education providers?

What that looks like I don't know, because currently we do that through the deans forums for medical nursing and allied health, so we have dialogue and discussions and the things like that. But currently at the state level, I think the governance predominantly sits on the health side of the fence and there's not that sort of partnership formally with education providers, but acknowledging that we aren't the only sector that is placing students.

Secondly, the policy that we've currently got around student placements is quite focused on the operationalisation of the student placement agreement, so kind of once those discussions and bargaining has happened between districts and education providers, then what are the sorts of rules and terms and conditions around how that can be done, although, as you have pointed out, deals are done which we don't have any visibility over and they're put as annexures to the student placement agreement and they could be different from that hospital and that one down the road.

So we don't have visibility over those things, and then I suppose there are potentially knock-on effects that might create that tension across education providers and that frustration around needing to broker with different districts.

The other part which you've been touching on is around the connectivity between what is the need that we have for our future workforce and, you know, if we think, "All right, we can see we're really going to need to beef up midwifery numbers out in that part of the state", what is our proposal around how we would be wanting to prioritise midwifery placements out in that part of the state, and then what are the mechanisms we do that through formally in partnership with education providers? I don't know the answer to that.

But the data and the work that Richard, as our leader, is doing with the other part of the branch, the workforce insights and transformation unit and the creation of the workforce planning centre of excellence with the future

workforce unit is those insights and intelligence and how do we connect that back into our discussions with the university providers through formalised ways, which then drives our response.

So your example of Brewarrina, if we have that as a really important issue, then yes, we want to allocate students out there, we would need to make sure they have supervision, and then we might need to put in place an initiative or a targeted nursing cadetship to say, you know, we offer four cadetships and if you agree to work there for two out of your first three years of postgrad, we will pay you. It's like they have done with the Rural Doctors Network, with the medical cadetships, which have shown to produce really good long-term outcomes in terms of sustaining people in rural practice. I think 64 per cent after 10 years are still working in MM3 to 7.

That was a longwinded kind of anecdote, but looking at the bigger picture rather than just the allocation, which currently is through ClinConnect, it's like a match-making system, you know, the districts put in how many positions are available, the universities go in and bid for them and then there's an outcome and it is monitored through that way. So that's just some thoughts.

MR MUSTON: In terms of that big picture that you speak of and the extent to which clinical placements and all the placements of students could potentially be used to address workforce challenges, accepting that there will be occasions when that won't work, that really has to happen centrally, doesn't it, for it to work effectively, because it is only the centre that has that visibility of the whole system that can see?

Whilst there might be a lot of perceived need in each of the different LHDs and they are all vying for placements, as are the universities vying for placements, but it's at the centre that you can look at it and say, "Well, we, based on the information we have, think that systemically the most appropriate way to distribute this future workforce is as follows, today." Next month, next year might be different.

MS DOMINISH: There are probably two components and I might get Richard to comment on this. There is a difference between determining that strategically and

doing it operationally. And so where is the balance currently and does that need to shift? Because I don't know that there is going to be value in us operationally allocated students across the state, but is there a mechanism to shift that - you know, with that visibility, determining more strategically what it is New South Wales needs in the future and therefore where the placements need to be.

I might see if Richard has a thought on that, if that's okay. It is complex, but it is a conversation we need to have, yes.

MR GRIFFITHS: I agree with you, I think, the value of centralisation or central visibility is that, that you can put that system lens over need and demand.

In terms of an approach, it really does need to be a close collaboration with those health organisations, though, because the service planning responsibility, while there is obviously an overall visibility that the ministry has in terms of service planning, that service planning responsibility rests with local health districts, and workforce obviously is an enabler to that. So it would need to be a very close collaboration with local health districts if we were to do a little more than what we're doing at the moment, which is allowing them to tell us what their capacity is.

I think the benefit of that sort of central visibility would be we could probably press a little harder and encourage more capacity than what we're doing at the moment.

MR MUSTON: For example, by including it as a KPI that an LHD has to meet, hypothetically?

MR GRIFFITHS: I think in coming to the decision around - because that would be how we would enforce it, but I think coming to the decision probably needs to be shared understanding of system capacity.

MR MUSTON: Of course.

MR GRIFFITHS: So at the moment that probably doesn't happen. It's very much the districts choose their student capacity and we facilitate it through a centralised system.

So I think there are things that we should be doing, but at the moment we're not.

MS DOMINISH: And I think there needs to be acknowledgment, though, of you can set a KPI, and I know we're talking about allied health this afternoon, but there has to be a recognition that someone does have to pay for the support that is being required for those students. So whether that's the health system or the education providers, there needs to be an acknowledgment of the burden of taking students - and I don't mean this in a negative way because it is absolutely part of our business to educate the future workforce, I've taken lots of students in my career and it is very rewarding, but we can't do that in isolation of recognising the rapid growth in the number of students and programs that have occurred over the last six years, which has not matched the growth of the health workforce.

If there aren't considerations for facilitators, clinical supervisors, educators, those enabling functions, to assist with increasing placement capacity, then setting a KPI only will be - we won't be able to achieve that.

Jacqui, did you want to --

MS CROSS: I just wanted to add, I think there is an assumption there that we need more, and given our supply of nurses in particular, I think it's more about the maldistribution example that you gave in that sort of rural area and perhaps it is looking at how you can focus in on them, rather than giving flat KPIs around the clinical placements across the board.

Certainly I know the data around COVID, for instance, we increased and maintained our clinical placements, and certainly when I've provided information the deans and heads of school have been quite positive about New South Wales' ability to actually support clinical placements. And I think again I said in my previous statement that we actually also provide clinical placements for people who are going to go into the private sector and into the aged care sector as well, so taking that on board. I think it's about thinking about what is the issue we're trying to solve.

MR MUSTON: Can I ask a question about that in terms of

providing clinical placements for people who are going to work into other sectors. Often, would it be the case that the particular students don't have a plan to go into another sector at the time that they're doing the placement, that's just where their trajectory takes them?

MS CROSS: That's just where they go, yes.

MR MUSTON: Would part of that problem be ameliorated by a wider-reaching version of Professor Baird's scheme in North Sydney which actually provides for a student who has conducted a placement in a home-based facility facilitated by perhaps a central body like HETI - we will come back to that - with an effectively guaranteed graduate position at the end such that they can actually see that career pathway into a facility, they might not spend their life working in that facility but at least it would have them working there from the get-go?

MS CROSS: I guess it will, yes. To me, when I think about that model, it is about actually the preparation and the pre-preparation and the socialisation, I guess, of that. If you are looking at it from a workforce supply point of view, I would argue that, as I said before, we currently have enough students enrolled, particularly - and we can attract them to all our metro areas, in fact we have more than we need, so I suppose you have to think about it in that way.

Coming back to my other point before, I think you just need to be mindful about making sure that we don't decrease the numbers that are coming through as well. So what is it that we need, how do we manage that, access to other universities within the same sites so we're not disadvantaging other students as well, I think that needs to be thought of too.

MS DOMINISH: I think just extending on what Jacqui said, in principle, that sounds and looks like a great idea. Breaking it down, there are enablers that currently exist in every district for districts to employ AINs, which are undergraduate nursing students, because we've got an award that allows us to do that, and districts within their budget capability can decide how many and where they are and that the supervision is available for them.

The issue around equity in recruitment policy is one

we have to note, because even with our cadetships, whether they are Aboriginal cadetships or the Rural Doctors Network cadetships, they still have to apply for and undergo a merit-based recruitment process at the completion of their degree. Obviously unless there is a catastrophic issue we're going to want to employ those people, but we can't assume that just because they have completed their degree, they are necessarily the right people for us to employ.

There is a double-edged sword there, given that the total number of nursing graduates, we can't employ every single one of those I'm assuming, based on budget and current capacity. That is something that we need to be mindful of just in terms of a limitation around suggesting this type of thing, even though in principle it sounds like a good idea.

PROFESSOR BAIRD: Can I just interject and say, just to clarify, THAT they would go through a recruitment process. They wouldn't just be automatically given the position; they would still have to apply and go through a recruitment process.

MR WHAITES: One of the important things - where do we sit on the whole centralisation/decentralisation question? I think there is a role for both. There are times when centralisation is really useful and important and times when you need that decentralisation for that local decision-making capacity to occur.

When you think about the student experience in the workplace, I support the comment that was made that in the smallest of places, there is just not the volume, the capacity to do that.

One of the important things is making sure that you have a workforce that has the psychological capacity - I think that's poorly framed - but given the workload pressures that our members talk about, the capacity to take on a student and mentor them during their clinical day, sometimes there is just not the brain space to do that, right, because of the other pressures, particularly if you are already working short or with a lower skill mix.

One of the key roles that exists within the award and within the workplaces is that of clinical nurse educators and clinical midwifery educators, and we know that at the

central level, particularly from NaMO, there is strong support and funding for those positions, but what we see at the local level is decisions to remove those positions or defund those positions.

We know of a new graduate coordinator, that position was defunded at a tertiary centre. One of the reasons why we think that occurs is because the local budgetary decisions that are being made are: is there a nurse and a midwife at a senior operational level that is able to influence those budget-making decisions? And too often we've seen senior nursing and midwifery positions left to having professional line responsibility rather than operational line responsibility. So some of that decision-making at the local level we feel would benefit from more centralised processes or oversight, but I do acknowledge the absolute complexity in trying to do that.

MS CROSS: Can I just clarify, the Nursing and Midwifery Office don't fund those positions. The positions are funded oftentimes through election commitments and the like; we just administer how those positions are administered and make sure that they're recruited to. I just draw that distinction.

MR WHAITES: My mistake.

MR MUSTON: Doesn't that point to the possibility - this is a question - that a central body like an appropriately resourced HETI, for example, responsible for dealing with student placements across the state and distributing student placements across the state and ensuring that appropriate resources are available at each local health district and funded within each local health district to deliver the experience that these students need, would be a preferable system to a system whereby individual institutions go with their own uniquely struck bargain, "Maybe we'll pay you some money for a student, maybe we will provide a supervisor here"; "Maybe providing a supervisor is better than some money so we'll take this university instead of that one", and also has the capacity to distribute those placements and cadetships and scholarships and whatever other tricks you might have up your sleeve in a more strategic way, and potentially graduate placements, acknowledging that not everyone can be employed?

MR GRIFFITHS: There is definite advantage in it, yes, and one of those advantages, obviously, is that you are going to have a closer alignment to student against vacancy.

I think one of the things that we're not doing at the moment is getting in and offering students who are proceeding through degrees roles while they're studying; we're waiting until they complete their degree. There's probably an opportunity to try and secure some of those graduates earlier in the process.

The challenge that we see is that districts decide their graduate numbers the year before, so there is an element of risk making decisions two years, three years out from the vacancy arising, because obviously you have that regular churn. But we're getting around that at the moment by locking people in to agreement to work in certain places.

The tertiary study subsidies program is an example, where we prioritise some of those subsidies and offer them on the basis that people will agree to work in some of our areas of need like some of our rural centres. So we're trying to overcome that through utilising some of those mechanisms, and we know at the time that people accept that they're well intended to work in those centres and that at the time when they complete and we offer them a role, that may change. But they are genuine, I believe, in agreeing to work in some of our areas of need. But we don't get in and do that early in the degree program, and I know that some of our competitor sectors are doing that, they are getting in an offering students roles early, before they complete.

My sort of hesitation around some of the arrangements that are in place at the moment is that, as I said, it tends to favour metro Sydney. We would want arrangements that push particularly nursing into the areas that they're needed. At the moment, we're grappling with agreements that universities have around where those students will be placed that are very limited, and so it would need to be unpicked. Some of that would need to be unpicked, and I think that would be a good thing, but that would be a difficult thing to unpick. But if we could do that, then we could have more control and influence over where those students go and we could then look at how we get them into the areas so that they are immersed in some of those

hospitals, because our research shows, or our research tells us that to get people, particularly city students, to stay in the country, they need to be immersed in practice in the country and the student placement is the first part of that. So there would be advantage to us to get them out into some of those areas.

If we could look to reform some of that, it would be great. It's just, as I said, there are 96 separate institutions that we would be up against in terms of unpicking some of those arrangements. And I know that some of those institutions, as well, have longstanding real estate arrangements in some of those facilities, so they're going to be reluctant to let those go.

MR MUSTON: As one of those 96 institutions or at least a representative of one of those 96 institutions, can I explore with you Professor Baird the potentially terrifying prospect of unpicking some of the arrangements that your institution has worked hard to broker. What is your view on the idea of centralising the student placement program so that student placements, potentially graduate positions and scholarships and cadetships, and a range of other levers and incentives that might be applied at the moment in the context of nursing and midwifery to deal with maldistribution? Is that something you think would be a positive or a negative, system-wide and from the perspective of your institution, the answers could be difficult.

PROFESSOR BAIRD: That's a really difficult question to answer, simply because of the factors that some of the other members of the panel have highlighted. It would be a logistical nightmare to try to unpick all of that. But I agree with Richard that should not stop us from maybe looking at what might be an alternative way of placing students.

For us I think we tend to focus on the acute area, and we forget about the primary sector, and I feel that that is an area that we could look at around placing students into there. I am really interested in when the practice review will be released - again, it's going to the minister in October - that Professor Mark McCormack has been leading, to look at scope of roles of people and how they can work in the primary sector. So I think it isn't just looking at is there a different way to do this; it's also

looking at are there areas that we could place student nurses, student midwives, to work in that would diversify the hospitals in the acute sector but also give them a bigger scope.

Certainly if you were thinking about rural areas, that's an ideal area where I feel primary health care is really important. I think you've got the conversation this afternoon around allied health, but it also encourages collaboration and co-working with other health professionals in the primary health sector.

MR MUSTON: Can I ask you about the issue that Mr Griffiths has raised about the metro-centric nature of a lot of the placements, driven largely by the fact that the large institutions like yours are metropolitan based. What are the opportunities and challenges, as you see them, associated with dispersing placements from an institution like yours more widely across the system?

PROFESSOR BAIRD: I think it's cost. For the student, too, in terms of finding accommodation. A lot of our students might not be able to move into rural areas because they've got family commitments. Nursing and midwifery continues to be a female-dominant profession and we attract students at all different ages, and some have families. So asking a student to leave their family and move to a rural area wouldn't suit everybody. But it's finding accommodation for them to stay, you know, I think there are financial constraints with that and that's where scholarships would be really important.

Most students enjoy the opportunity of a rural placement. The length of time might be a big factor. But often we find when some of our students do go on a rural placement, they really enjoy that placement and think about, "Is that somewhere I could move my family to or is that somewhere where I could work?" But there needs to be more planning and thinking around how we would support a long-term placement in a rural area for a student that lives in South West Sydney and what that would mean.

MR MUSTON: Could I also ask you a question Mr Griffiths raised earlier, about what he perceives to be value in trying to identify in a more common way what the student experience, delivered through a placement, should be. I inferred from that that different institutions might have

subtly different views about that. First of all, is that inference right in the sense that is the student experience to be delivered through a placement something which is driven by a particular course structure and syllabus at one institution which might be different subtly to another?

PROFESSOR BAIRD: It shouldn't vary too much because we all have to follow the accreditation standards set down by our professional body and each program that is accredited and reaccredited through the Nursing and Midwifery Board of Australia, through ANMAC, our Australian Nursing and Midwifery Accreditation Council, all have to meet the same standards or the program does not get accredited. The learning objectives should be the same for every single student regardless of what university they come from, so that should not be an issue. How that institution might deliver those standards might vary, but we should all be delivering the same programs of education in nursing and midwifery.

MR MUSTON: Is there scope, to pick up on a suggestion that Mr Griffiths made, for institutions, including yours, to come together with the ministry and settle upon, in effect, a common way in which those experiences are delivered through the placement program so as to enable there to be certainty and perhaps even portability of students from different institutions and different LHDs to the extent that that might be possible and desirable?

PROFESSOR BAIRD: We would welcome any conversation that might happen around future student placements, absolutely, but until we would know what that would look like, it would be hard to comment on what the outcome might be.

MR MUSTON: Not wanting to sound like a broken record, but would that process be better facilitated by a centralised process dealing with the allocation of placements than, say, individual arrangements between institutions and LHDs?

PROFESSOR BAIRD: Again, that's hard to predict until we would know what that would actually look at. Certainly at the university we have longstanding relationships that we have built up and we highly value those relationships, as we do with our relationship with the ministry, so we would be happy to be involved in any future dialogue around student placements.

MR MUSTON: Did anyone else want to comment on that one?

MS DOMINISH: I agree it is really hard. I think if anything was centralised, there would need to be consideration for the preservation of the relationships between the providers and the local health districts, acknowledging that not every provider will be dealing wither local health district, but there's inherent benefits that both the health system and the education providers have realised through those relationships over time, and it's an important enabler to the ongoing willingness of the health system to take students but also, I suppose - yes.

MS CROSS: Kathleen might be able to help me here, I'm just struggling to remember, but certainly I know that there has been work done in the past trying to get a uniform assessment of students from different universities, so in the clinical placements, they will be assessed against certain skills, and I know there have been attempts to actually standardise that and it hasn't been successful. They haven't been successful, have they?

PROFESSOR BAIRD: They actually have. Again, going back to the education standards for nursing and midwifery, every student should be assessed using what they call the AMSAT or the ANSAT tool, which looks at all the different areas around - depending on where the student is at in those three-year, if we look at nursing and midwifery, bachelor programs. So it's not just about clinical skills, it's about communication, their ability to work as part of a team, and three or four times a year each student should be assessed using the same tool so it's fair and transparent around what we're actually measuring.

That should be standard across every single university. They should all be using the same tool. But there might be other differences that we don't have any control over but certainly around assessments. That's the important role that ANMAC has when it comes out to visit a university, before it approves an education program, to make sure that a program is safe, will meet the standards of education and that every hospital can feel safe that the students have all been assessed in the same way, at the same level.

MS CROSS: I guess I'm speaking to about where the curriculum plays out and where clinical placements are

sequenced and scheduled within that curriculum. Sometimes that can be a challenge for the staff on the wards who are supporting them, knowing in a different university they might be up to a different stage, so what are they actually assessing against.

PROFESSOR BAIRD: I think that is a problem if you've got two or three universities all going to one hospital, that nursing and midwifery educator or nurse midwife has to have some form of clarification around what year is this student currently at and what level should I be assessing for that. But again, that information is there to support them in making that assessment.

Probably why relationships are really important is they will pick up the phone and they'll say, "I have a concern about a student", and we'll just talk, you know, we'll talk that through.

I have to say we feel our students are very well supported in clinical practice, both in nursing and midwifery. We have no concerns in that area. But it can be challenging if you've got several universities and the students all want to be out in the clinical practice at the same time, and that might need some negotiation to make sure that the staff aren't overwhelmed with too many students. So it is, as I said earlier, a bit of a jigsaw puzzle and it can be a bit of a logistic nightmare for some of our hospitals trying to manage student placements.

MR MUSTON: Ms Dominish, you were going to make a comment.

MS DOMINISH: Yes, I think throwing the cat amongst the pigeons a little bit, the concept of the scheduling is definitely something that is a challenge for the health service, due to the ebbs and flows of activity and pressures of winter and all of those kinds of things that occur across the year. But even within each discipline, having universities placement blocks kind of all over the year in different ways is a challenge.

Again, not an easy solution because it is a jigsaw puzzle, but certainly in other states - there is an example in physiotherapy in Queensland where they managed to get every university to agree to the same placement blocks and they all run at the same time every year, so that the service is really prepared and understands when things

start and stop and what years are happening at what times, and that makes it much more predictable from a service perspective to incorporate students but continue with your clinical services. So it's not an easy thing to do but I think there's an opportunity, perhaps, how can the education providers adapt to make it a bit easier for us.

MS CROSS: Just on that, too, I think around when they can be scheduled as well. So certainly with things like night duty, I know some of the districts are interested in being able to support students on night duty because that's real life for a nurse, and how do we sort of work through that with the universities as well.

MR WHAITES: The comment I was just going to make is I can't disagree with any of the points and the problems that have been outlined there, but when you're looking at the question of maldistribution, the major regional hospitals have university relationships, have their students coming and going. The opportunity for those students to go into minor regional hospitals, the remote hospitals, the economic barrier faced by the students themselves is the hurdle to overcome.

It used to be that hospitals had nursing accommodation attached to them. Economic rationalism got rid of all of those. For a student to be able to afford transport to the site, accommodate themselves, feed themselves on top of the university course costs, no amount of coordination and centralisation is going to fix that unless you fix the student poverty or provide those as part of the student experience.

MR GRIFFITHS: I don't disagree. The other thing is, in looking at student placements, you need to consider how wide you go, because, as I said before, we're not the only provider of training for student placements, and for us it's a $350 million operation each year. We get some of that back, but we're still in the vicinity of $150 million to $200 million it costs us, and I will sort of put two positions forward. One is that we're wearing the burden of training for our competitors, at the moment. There is training that occurs in those sectors but the bulk occurs in the public system. Some will say, "Well, that's your role as the public sector; you are the training organisation." But on the other hand, if you're going to do a review of student placements in the health system,

that then - I will use the term "unfairly" - sort of swings people into the public sector, you then starve the other sector of supply.

So I think if you really want to look at it, it's bringing those sectors to the table as well. So we're losing workforce at the moment, for example, to NDIS, to aged care and to private health. There's no reason why those sectors couldn't be in the training - and they are, to a degree. But I think whatever you do, you need to take into account what the impact is going to be for those sectors as well, because it could unfairly impact them by moving students across into the public sector.

MR MUSTON: In what way are they moved across into the public sector? If the idea is just a greater coordination of the existing students within the public sector, how does that impact on the private sector?

MR GRIFFITHS: If you have a blue-sky sort of picture where we've student experience so fantastic in the public sector they're only going to work with us and we end up making it difficult for our competitor sectors. There is a little bit of an altruistic type of contribution that we make to the sector because we are the public sector. I just think that if we're really serious about it, and if we're going to do unpicking, then we probably have to factor in those other sectors as well.

MR MUSTON: Can I move away from the student placement experience and just ask a couple of questions about the way in which workforce data, the available workforce data, is used in recruitment. Again, recruitment, as I understand, is done largely in a devolved way, so a particular facility in a particular LHD needs a nurse or a midwife, they will enter the market to try and find one.

MR GRIFFITHS: Correct.

MR MUSTON: And there may, at any particular point in time, be more positions advertised for, say, midwives, for example, than there are people wanting or able to apply for those jobs.

MR GRIFFITHS: Yes.

MR MUSTON: Has any consideration been given - well, let

me take it back a step. To what extent, if any, so far as you're aware, is the workforce data that you have available centrally utilised in decision-making about where to be offering positions, particularly in areas of extreme shortage, like midwifery?

MR GRIFFITHS: The exception to what you have said there is new graduate recruitment, which is centrally recruited.

MR MUSTON: Just pausing there, when you say that new graduate recruitment is centrally recruited, how does that actually operate in terms of deciding whether or not a graduate midwife goes to Cooma as opposed to North Shore, for example.

MS CROSS: The districts still put the positions up that they want to recruit to. So it's still determined by the districts.

MR MUSTON: It is just the process of recruitment happens centrally so you make one application for multiple roles?

MS CROSS: Yes, and we filter them out to the districts.

MR GRIFFITHS: Sorry, the second part of your question?

MR MUSTON: The second part of my question was to what extent, let it be assumed that there's - pick an easy number - 10 midwife positions available across the state, whether it be graduate or more experienced people. There are five people who are applying for them. To what extent, if any, is the workforce data you have about immediate workforce needs and projected workforce needs taken into account in deciding where those positions should be offered and filled?

MR GRIFFITHS: Well, it's definitely devolved, at the moment. The local health districts are making decisions. If you're going to utilise a central coordination process to really influence some of those appointments, you have to turn off some recruitment in an area so that the only available position is the one that you want to fill, which we don't do at the moment. So the districts really take responsibility for filling their staff establishment.

If we were to move down that path, that's what it would need to involve. So if we know that there's

recruitment that is challenging in Brewarrina, then you switch off RPA and only have the positions available at Bree. But the problem is people know that it is sequential and that those positions will become available. So whether that assists or not would be tested, I think.

MR MUSTON: Is there any utility in a more centralised approach to recruitment? That's probably a very broad question. From the point of workforce distribution as a first lens, is there an advantage, do you think, to centralising the recruitment process in that way?

MR GRIFFITHS: I'm just trying to think through what it would deliver. The process is standardised, so even though it's not centralised, it's standardised across the state. Whether we could influence positions more so than what the districts are doing, I don't know, because really, we're trying to do that through offering incentives in certain areas. It is really up to the person to apply to where they would prefer to work.

Under our Act we can't just move a person and directly appoint them where they need to be, unlike some of the other services. So if we were to move down that type of path, then you could really influence the pipeline and directly appoint them to where they need to be appointed, with appropriate sort of conversation.

The challenge that we have at the moment is that we can't force people to go in a particular place. We encourage it, we incentivise it, we probably need to do a little more in selling some of the rewards of those incentives.

For example, in our incentives program, we've got the capacity to incentivise a transfer. We haven't done one yet, and it's only a new policy, so it's making sure that people understand that facility is there. The way that that would work is for some of those very challenged areas, ahead of the person accepting a role, they could negotiate a term out there, say two years, and in return, they could basically pick a hospital where they wanted at the end of that term, similar to the points system that the education system used to run, or still do to a degree.

That might encourage people to go to some of those areas, knowing that they've got the capacity to get

a priority transfer back. So we'll need to do more in selling those sorts of things. But in terms of centralising recruitment itself, it is hard because we don't have that lever to pull, which is that directed transfer.

MR MUSTON: In terms of the centralised recruitment process as a possibility, does it also have an additional benefit, a similar upside to the graduate recruitment process, where however many positions there might be available out there in the health system, you fill out one application form, you tick the boxes that identify which particular positions you might be interested in, accreditation in terms of your skills and your qualification to do any one of those jobs is dealt with once and centrally rather than each LHD receiving a separate application, going through each of those processes separately?

MR GRIFFITHS: We do that to a degree for new grad nurses, for JMOs.

MS CROSS: New graduates are able to prioritise where they want to go, say if it's 1 to 8, if they get their first preference they are interviewed there, but if they're not successful then they go into an eligibility --

MR MUSTON: That works for the graduates. What I had in mind was more once you've gone through that graduate process and you may be 10 years into your career, you say "I would like a job. There's one in Brewarrina, one in Wagga, one in Dubbo, I'll take any one of those jobs because I might not get to choose, so I will have to apply for all of them", which potentially has you filling out multiple applications, being accredited across at least two local health districts, potentially having things like your working with children checks and all those sorts of things having to be done twice. Is there some utility in centralising that in a way that means the actual recruitment process is streamlined to reduce - whilst people might still identify where they want to go out there in the system, they may not be having to effectively run their own race with each individual position and each individual facility?

MR GRIFFITHS: Yes, there would be utility in that and there are things that we're doing moving towards that type

of outcome at the moment. So we've got work under way that is designing processes that you really come into health, you're screened once for health, and that carries across with you everywhere you go, so we're calling it a "checks passport", so that, you know, all your relevant screening is done and then you can sort of move about the system more easily without needing to go through all of those very time-consuming type of recruitment processes. So, yes, we're definitely moving towards that. There's a bit of a way to go.

Local health districts don't want to lose their autonomy of choosing their workforce as well because that culture fit assessment is very important. So there does need to be some element of recruiting managers being able to pick. But we're designing a process that sort of brings about a better candidate experience, because that is feedback that we've heard, that our processes are complex and not particularly candidate friendly. I know that we're not alone, though, in that. I know that our competitors, their processes are equally as candidate unfriendly. However, we know that that's going to have to be work that we do in order to improve our value proposition.

MR WHAITES: We get a lot of feedback from members who are managers, members who are going through the employment process, and NSW Health unfortunately has a reputation for being slow, people, as you say, putting in multiple applications looking for work and often the private sector is quicker, from interview to phoning them up to say "You've been successful. When can you start", and that on-boarding. I think it does vary, depending on the LHDs, but certainly there is more work to be done there, yes.

I think one of the comments about the incentive schemes that both the government and ministry have brought in - you can understand why they're doing those things, but there are unintended consequences. Whilst you might support the $20,000 bonus sign-on to become a midwife in rural New South Wales, for the midwives that are already working there, that's, you know, an undervaluation moment from their perspective, and we see the application of those incentive programs causing some tensions within the workplace as one group gets the retention or bonus and others don't.

So they are useful but we think there needs to be more

work there, and, of course, we would go back to that central message of, you know, we know that nursing and midwifery has the highest proportion of ads placed out for vacancies but the lowest amount of people applying for it. I think SEEK reports nursing as being their highest disparity. You would assume if economic rationalism and the market forces were playing out appropriately, then the wages would be driven up and that would take care of itself. I think, you know, wages generally are the approach to getting some of that maldistribution, even if you are looking at - for instance, there is an allowance.. if you work out at Broken Hill, there is an allowance that kicks in against an imaginary line drawn through the state. Whether or not we review that in the longer term as to how that might encourage people to relocate is another option.

MR MUSTON: I note the time. I was going to ask one last question about scope of practice, if I could. From the point of view of, to pick up on I think a term Mr Whaites used, "value" and the extents to which you are valued in your workplace, does ensuring that every layer of the workforce or every contributor to the nursing and midwifery workforce is able to work at the top of their scope as best as possible and not be overly burdened by things which might be at the bottom of their scope, does that enhance your recruitment and retention particularly to areas where maldistribution is biting?

MR WHAITES: Yes, I think absolutely, particularly in certain areas. Midwives talk a lot about desire to work more autonomously and certainly their scope of practice allows for that. The ability for more positions around nurse practitioners or advanced practice nurses, so that people see a career progression for them and a growth in their clinical area of application certainly makes work more satisfying. It is not just nursing and midwifery, there's so much evidence around that as a way to get people engaged in their profession.

MS CROSS: And I was going to say also, we often talk about that high end, so, you know, we're talking about nurse practitioners and the nurses who can put in long lines using ultrasound or whatever, but there's also, I guess, other skills that sort of sit, that we need to look at and say, "This is the domain of registered nurses." Certainly some of the feedback we're getting, particularly from nurses who are arriving from the UK, is that there are

things that our nurses are not engaged in, which we could have a look at. I think some of that is, and anyone who knows me knows I talk about venipuncture and cannulation - that's a bugbear of mine, I believe that all nurses and midwives should do that as a foundational skill, and I think that's about access to care and timely access to care. But I think what we could do as a state as well is look at the education, look at what the assessment looks like for those particular skills, how we are able to transfer those skills once they're accredited as well. I think there is a set of similar skills that we could look at prioritising and I do think there is something there that we could have a look at too, certainly supporting our nurses to work to.

MR MUSTON: And potentially another reason why a slightly greater centralised control of the student placement process might be a good idea, possibly.

MS CROSS: I'd say it is about the workforce we already have, too.

MS DOMINISH: I think the benefit of that - well, we don't want to deskill people the minute they graduate. So we have to do, as Jacqui's highlighted and Michael mentioned too, some work I think particularly with nursing and midwifery to accelerate where are those high-value opportunities that we're not taking advantage of and are there things that we are deskilling people in immediately on graduation - so Jacqui's example of cannulation and venipuncture, nurses are trained to do that in their undergraduate training but why is it they are not perhaps doing it in the system when they should be? We don't want to expend money retraining people for things that they have already been trained to do. But equally with the pressures of the system, what are the high volume, high value activities where nurses could really bring - and midwives - their capabilities?

The recent piece of work that has been done for the emergency department, and I know it has been talked about in evidence, the ECAT protocolised care, really enhances the ability of nurses in the ED to optimise their scope of practice in that setting. The reward for a clinician is it may not be something completely complicated but it means you get an instant satisfaction from the patient's experience that they're not having to wait around for

a cannula to be put in so that someone can give them pain relief or fluids or whatever it is that they need. So that's as a clinician I think the reward that you get from being able to just get on and do the things that you are trained to do.

MR MUSTON: I note the time, Commissioner. I think that probably exhausts our discussion about nursing and midwifery this morning, unless you had any other issue you wanted to raise or any of you had any other particular burning issue that you wanted to raise.

MR WHAITES: Just one other quick comment. When we talk about scope of practice - as Jacqui said, we talk about the various levels - we also can't forget some of the fundamentals of nursing and midwifery, in particular, nursing, where we often see another classification of worker brought in or attempted to be brought in in order to take on what we say are nursing duties.

One of the fundamentals for that is showering a patient, as an example. A registered nurse will tell you that's the moment where they're doing a gait assessment, where they're doing a skin integrity assessment, they're looking at the person's capacity to attend to their own activities of daily living. This all forms part of the holistic approach that nurses take to the patient care that they are providing.

It's not as simple as the very high-end stuff where we talk about endorsed midwives or nurse practitioners, that middle level stuff about cannulation, when you look at the scope of practice for nurses, they really are an absolute value-add to the hospital system, because of their breadth and scope.

MS DOMINISH: I would agree.

MS CROSS: And I think the other bit that we don't capture very well is that the essence of what we do is about that evaluation and assessment, and we're doing that in all sorts of ways and all sorts of times, when we're showering a patient, putting that cannula in, when we're talking to their family. So we don't actually capture that well and I think that's the fundamental part of what we do.

MR MUSTON: Do I take it from that that one would need to

be very careful about teasing out particular tasks and saying, "This is not a top of scope task for a registered nurse, therefore, an enrolled nurse or an assistant in nursing can do this", because, in fact, built into that task that might to a layperson appear as though it's at that lower level of scope may be, in fact, some part of that important higher scope?

MS CROSS: And it is about how the whole team come together.

MS DOMINISH: I think nurses and midwives are the only people who really see patients at every hour of the day. They see them through that cycle of in the middle of the night when things are falling part, or first thing in the morning, they can see their change in behaviour and their change in function, so, yes, agree that that value should be well recognised.

THE COMMISSIONER: I have some questions on the new statements. It is actually from the new statements of Mr Griffiths and Ms Dominish, so perhaps we can do it as part of the next panel, because they're coming back. That might be the easiest thing.

MR MUSTON: Sure.

THE COMMISSIONER: All right. We will adjourn until 10 past 2. To Mr Whaites, Professor Baird and Ms Cross, thank you very much for your attendance. We're very grateful for your assistance today and we'll come back with the next panel at 10 past 2. We'll adjourn until then.

<WITNESS WHAITES WITHDREW

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LUNCHEON ADJOURNMENT

MR MUSTON: The second panel for the day, from your left to your right, we have Professor Newton-John, head of allied health at UTS, Professor Debra Anderson, the dean of health at UTS, Richard Griffiths, who we already know, and Jacqueline Dominish, who we already know from this morning.

<TOBIAS ROBERT OLIVER NEWTON-JOHN, sworn: [2.11pm]

<DEBRA JANE ANDERSON, sworn:

MR MUSTON: Professor Newton-John, could you state your full name for the record, please.

PROFESSOR NEWTON-JOHN: Tobias Robert Oliver Newton-John.

MR MUSTON: Professor Anderson, could you give us your full name, please.

PROFESSOR ANDERSON: Debra Jane Anderson.

MR MUSTON: Both of you have participated I think in the preparation of a statement prepared on behalf of the University of Technology dated 1 October 2024?

PROFESSOR ANDERSON: Yes, that's correct.

PROFESSOR NEWTON-JOHN: That's correct.

MR MUSTON: You have had an opportunity to review that before coming to give your evidence today?

PROFESSOR NEWTON-JOHN: Yes we have.

PROFESSOR ANDERSON: We have.

MR MUSTON: You are satisfied that its contents are, to the best of your knowledge, true and correct?

PROFESSOR NEWTON-JOHN: Yes.

PROFESSOR ANDERSON: Yes, we are.

MR MUSTON: Commissioner, that's at document L18.

Can I start by perhaps asking you, Professor Newton-John, what you see as the significant workforce challenges as they apply in the allied health space?

PROFESSOR NEWTON-JOHN: Workforce challenges in the sense from the university perspective?

MR MUSTON: From the university's perspective, in terms of feeding allied health students, then graduates, into the workforce to make up part of the public health workforce.

PROFESSOR NEWTON-JOHN: There are number of constraints, obviously, and one of them top of mind is the clinical placement situation. In a number of our disciplines we have quite a number more applicants than we have places to give to students, and there are obviously a number of reasons, limiting factors there, but the lack of availability of clinical placements for many disciplines is a major one, and so the opportunity for us to expand our courses and train more allied health professionals is dependent on those students being supervised in the field, and the availability of field supervision places is very limited in a number of our disciplines.

MR MUSTON: Do you get the sense, and perhaps this is more a question for you, Mr Griffiths, that within the allied health disciplines, and again break them down if you need to, there are sufficient graduates being produced to meet workforce, present and future workforce needs, or is there a disconnect?

MR GRIFFITHS: There is a bit of a shortfall. The modelling has shown that even some of the areas where we were more comfortably supplied, because of the NDIS, we're now seeing shortages - so physios, OTs, social workers. So it's hard because it's a group of 23 separate disciplines, but on the whole, most of those disciplines now are challenged in terms of supply.

MR MUSTON: And picking up on a discussion this morning, in relation to the ability of the public health system to provide placements for students in these disciplines, particularly in areas of need, are there things that could, in your view, be done differently to increase the number of student placements that the system is able to offer to students?

MR GRIFFITHS: Again, further to the conversation we had this morning, I think so. I think there are opportunities that we perhaps influence the system to create some additional capacity.

The challenge with allied health, outside of metro, a lot of the allied health roles are fractionated, so you

may not have the supervision to support the student during the placement. Metro is a little easier because we don't necessarily see that fractionated appointment in Sydney.

I think there is an opportunity for us to perhaps become a little more involved in influencing the capacity across the system.

MR MUSTON: Coming back to you, Professor Newton-John, do you, from the position that you occupy, have a sense of whether the placements dictate or drive people to employment in particular areas?

PROFESSOR NEWTON-JOHN: Yes, actually, quite strongly. I've been interested in this for some time in terms of where our graduates, our new graduates, get their first job. We have alumni groups, so we can follow this up, and it's more the case than not, actually, that students will get their first position from a clinical placement they have had, and that has been enormously valuable, both to the student, of course, and to the employer. I'm talking about not just in health but private practice as well - it's across the different environments. But students who have the opportunity and the employer who has the opportunity to test each other out, to experience the workplace, to experience the quality of the student, if there's a position going, it's a natural sort of extension then to employ that student.

MR MUSTON: With the placements, do the placements that allied health students from your institution, for example, take up - are they divided across the public and non-public system?

PROFESSOR NEWTON-JOHN: They are, yes.

MR MUSTON: What sort of places do students tend to go for their placements?

PROFESSOR NEWTON-JOHN: They can go for anything from acute hospital care to chronic rehabilitation hospital care to private practices, community health, sometimes NGOs if there is an opportunity there. The students need the hours for their qualification and the universities need the appropriate supervisory experience in place, but diversity of experience is a big thing for students, so an opportunity to go, as long as it meets the requirements of

a placement, we will always look at it, and partly that is, too, genuinely because they are not easy to come by, so having that diversity is important but also a practical measure for us, too.

MR MUSTON: From the university's perspective, what is the process that the university engages in to secure placements for students within the allied health space?

PROFESSOR NEWTON-JOHN: It varies according to the discipline, and there are many of them, of course, but if we take clinical psychology as an example, generally, it comes down to our clinical placement coordinator reaching out to the profession and asking, "Does anyone have any capacity to supervise one, two, or X number of students?" There's a negotiation that takes place between that individual potential supervisor and the university. It can often hinge on sort of the loyalty that that supervisor may have to the institution or whether they have got a particularly busy semester or busy work period. It's actually pretty ad hoc and we're often finding ourselves left short in that it's very difficult to predict how many clinical placement positions you will have for any one discipline. So it tends to operate on the basis of individual connection between a placement coordinator and the facility offering a placement.

MR MUSTON: This might be a question for you, Professor Anderson, given your likely oversight over both, but is the placement and securing of placements within allied health, different to the securing of placements in nursing and midwifery, for example?

PROFESSOR ANDERSON: Yes, it is. So what we see is that I think nursing and midwifery has been doing this a bit longer and has a more sophisticated - what I would say is a sophisticated approach. I think that's just because of the historical nature and the broad scope that we've looked at across other states across Australia and looked at models there.

But what we do find with allied health and as we bring on new allied health, for example, last year we started with a bachelor of psychology, we find ourselves really in a different situation of really relying on partnerships to be able to kindly provide us with clinical placement, so there is a lot of negotiation that has to take place,

whereas I think with nursing and midwifery, the expectation, we have a lot of students that we find clinical placements for, and some of the models that we've got where we are getting clinical placements, I would say are a little bit more advanced. For example, we work solidly with certain local health districts with different models of clinical placements.

We have now been working with those health districts to negotiate, for example, exercise physiology placements, for the first year, we were able to put them into clinical placements within the local health district; psychology, speech pathology. So those are the types now. We're trying to look at will those models work as well. So it is a bit different.

MR MUSTON: Ms Dominish, I think you were wanting to add something.

MS DOMINISH: I think going into this conversation, it's probably useful for me again to paint the context of allied health and how this differs from nursing and midwifery and medicine, particularly around the history and the structure and function around clinical placements.

So at a fundamental level if we just look at the workforce for allied health, and the way we work in the district, so I will start with as a profession. So the majority of allied health professionals, your whole training is done in your undergraduate space. So not like medical, when you finish and then there's ongoing levels and training that are structured and there's infrastructure that pushes you through up to your consultant level; for allied health, those four years - it is generally four years that you undertake in your undergraduate degree - is what then gives you your licence, whether it is through general registration or through the recognition of the qualification to practise independently. The practice of allied health professionals --

MR MUSTON: Pausing there, are there some allied health areas where you get your undergraduate degree but in order to get your licence, to use your term, you need to have a postgraduate qualification? I think psychology might be one of those.

MS DOMINISH: Correct, yes. Psychology is a part of

difference, also pharmacy has an internship year, and professions like genetic counselling also require additional exams and placements in order to sort of get your full ticket to practise.

But once that is completed, the way an allied health professional practises is independently, and generally one-on-one with a patient. So we don't work in a hierarchy, we don't have teams of people that work around us, and when you're working in rural areas - like, you are on your own. You are a sole practitioner.

What Richard was mentioning before - so that's the training for allied health, and then the way you get better and you specialise and you get more skilled is through luck of the draw, through ad hoc professional development courses, experience and moving around different positions in the system and specialties.

In terms of the FTE and the way we're employed in the system, unlike nursing and midwifery and medicine, we don't have agency workforce, we don't have - I'm saying "we" because that's my foundational discipline, it's a bad habit. Allied health doesn't have agency, they don't have locums, and very few districts have reliable casual pools. So from a workload perspective, when there are shortages or we can't fill positions, the existing staff will carry the workload. So there is no ad hoc bring someone in on a shift, get someone in to help with the workload, and that's important because when you are looking at the ability to take students on clinical placements, you don't have that back-up in support for the clinician and their day-to-day clinical work.

The final thing I want to say is that, looking at nursing and midwifery, for student placements in nursing and midwifery there are dedicated facilitators of placements that are funded by the universities to enable the student placements to occur and for the students to be supported on top of coordinator roles in the districts. That is in the context of also nursing having clinical nurse educators, which we spoke about this morning, which is the support for the professional staff, the qualified staff, and they also support those qualified staff in their skills and capabilities and confidence in being able to supervise students and other more junior staff.

So I think it's just important to paint the picture of the infrastructure that exists in other professions compared to allied health.

I can talk a bit more about the educators and things. In the allied health context, then - and there's a report that has been attached to Richard Griffiths' statement, which the ministry has just done, part of my team, around allied health educators, and I suppose the concern that exists around the lack of the number of educators that have grown over time, and it has really been dependent on individual districts deciding to invest in those roles and it is very ad hoc.

The challenge for allied health also is you couldn't have a social work educator trying to lead clinical practice and supervision of pharmacy. Like, they are totally different professions. And so in building that capability, there needs to be consideration for what is required for the size of the profession at a local level in addition to, perhaps, smaller professions that might require a higher level state-wide approach because of size.

So there hasn't been, to my knowledge, any centralised investment in allied health educators since the Garling inquiry, and that was specifically around pharmacy. There was some investment there due to the need to support novice professionals transitioning to the workplace and the critical importance of medication and medication safety.

But other than that, it's a challenge, because if we're wanting to increase placement capacity, which I think there is goodwill from the allied health workforce to do, there has to be recognition that that comes at a cost from a wellbeing, a capacity and a financial perspective, and because there's no consistent approach to that or recognition of that, and you add that on top of not being able to back-fill vacancies, or fractional appointments in rural areas, where you may not even have a supervisor workforce available - I just think it's important that it is painted as a different context to the other professions.

MR MUSTON: But in relation to that, what is it that is driving the different approaches to the funding of that training workforce district to district? Is it just budgetary constraints or is it inability to attract that workforce or some combination of the two?

MR GRIFFITHS: It's scale.

MS DOMINISH: It's scale. It is, I think, potentially - you know, I suppose it's profile and who makes the most noise and over time where the priorities have been put.

Obviously nursing is a big workforce and there's a history around the structure of nursing which has evolved over time, and perhaps it's just not been the visibility and, I suppose, level of importance that has been placed on that, either from a central level, both in the health and education sector as well as the local health district level. And I think now is a critical point, because we're seeing severe shortages, particularly in professions like radiation therapy, we're very worried about podiatry, OT, the bottom fell out of OT during COVID when the NDIS hit its full scale. So really, if we want to address this, that has to be part of the conversation around what is the support that is being provided for the clinicians.

The other point I would make is that in addition to the clinical - you've got your health professional educator roles and then you've got your student educator roles and sometimes they can be discipline specific. I gave the example around pharmacy and social work, and sometimes generally in the qualified workforces we do have some general educators across professions, but the levers that we have available to us in New South Wales, there is not anything built into the award around things like payments for student supervision. So in Queensland, that has been built in to their award. We haven't had the investment or recognition of the importance of clinical educator workforce.

And then there's also things like allied health assistant positions, which we do have the ability to employ people as allied health assistants from an award perspective, where we could bring people studying into those roles, like we spoke earlier today about nursing - again, it comes down to where does the budget go and what is the priority.

So there's a number of things we could do, but it's really about what are the priorities and where does that investment go.

MR MUSTON: Mr Griffiths or Ms Dominish, in terms of the need for that investment, if it is not made and things remain in the status quo, what is that going to do in terms of the adequacy of the health service, in particular its ability to deliver the allied health care that presumably is an important part of any public health system?

MS DOMINISH: I will just make one comment and maybe pass to Richard. Twofold. One is the ability for us to train that future workforce and to do it in a way that is robust, that's evidence based, that gives them the skills that they require and transitions new graduates to practise in a way that they can immediately make a contribution; then, secondly, for our professional workforce, is ensuring that what we're doing when we're talking about optimising scopes and practice and changing models of care and adapting to the way that we are delivering service, there is no doubt that the role of allied health professionals in the future workforce is critical with the complexity and multi-comorbidities that people have, so we're at a critical point in time where we need to look at this I think more closely, about what our response is going to be, to future-proof what we're doing.

MR GRIFFITHS: The only thing I would add to that is, we need to do something, because the modelling is suggesting that we need to invest each year in additional grads in order to meet demand. So we do need to do something, and as I interjected in Ms Dominish's evidence just beforehand, the issue is scale, with allied health, which presents some operational difficulty for us because you've got about the same number of allied health practitioners as you do doctors, but you've got to divide that by 23 disciplines and then divide that by 17 organisations. So the spread is very thin and a lot of those appointments, because of the nature of the activity, are parts of an FTE, so a fractionated appointment.

We are trying to determine at the moment how we can really address the pipeline, taking into account those challenges, and one of the things that we really need to work on, and we've pulled the deans of allied health in for a conversation about this, is the student placement experience, and part of that is the employment proposition for the public sector, getting in early, looking at employing graduates earlier in their program and not waiting until they graduate, because as I said this

morning, I am aware that our competitors are in there employing them earlier. I can see nodding from the table.

PROFESSOR NEWTON-JOHN: Yes.

MR GRIFFITHS: So we know that we need to do something along those lines, but we need to do it in a way that's sustainable because of the nature of the spread of allied health.

The other thing we worry about is I don't know that we really have a true picture of allied health demand, because if there is no service to refer to there won't necessarily be a stat that we can capture. That referral information will be missing, because there's no-one to refer to.

MR MUSTON: So I can understand that, you might have the absence of a speech pathologist in a particular LHD, which means people aren't being referred to the LHD's speech pathologist, which means you don't have data saying, "Here is the number of people each day, week, month, who are being referred to this is service", but that doesn't mean there's not demand --

MR GRIFFITHS: Correct.

MR MUSTON: -- it just means that it's demand which is not captured by your internal systems.

MR GRIFFITHS: That's right. We need to do a much deeper dive into the activity to try to determine what the demand is for allied health. It's probably a little bit of an elastic commodity in a way: if you build it, they will come. But the absence of that is the same in reverse: if it's not there, it's not going to exist in terms of referral data.

So we know that we need to do something different. We've got to look at incentivising allied health graduates into the health system, but as I said, the challenge is doing it in a way that's sustainable.

MS DOMINISH: Just to add to that from the conversations we've had with the allied health deans - when I say "allied health deans", it is not like nursing and medicine where there is one person in every place you go to. If you're in the University of Sydney there are three, four or five

different schools you have to liaise with, but with the aggregate group that we talked to, one of the absolute determinants of whether someone will come back and work with you is the experience they have had with their clinical supervisor. If they've had a bad experience with their clinical supervisor, they will have no intent on coming back to work for us.

That relationship, particularly in allied health, because it is often very one to one, between the student and the clinical supervisor, is something that is nurtured and enabled through a student educator, because that person supports the student but also supports the breadth of clinicians who are trying to provide a good quality experience for students needing to meet their capability requirements as part of their placement experience.

The other thing that makes it a bit tricky when we start talking about transitioning into employment is, unlike medicine and nursing and midwifery, allied health, aside from a program that runs voluntarily with physiotherapy, does not have any centralised recruitment processes. There's no new grad statewide program. Years and years and years ago there used to be new graduate positions that were highly competitive and people really wanted to work for us, and I'm pretty sure there are a lot of people that want to work for us --

PROFESSOR NEWTON-JOHN: Absolutely.

MS DOMINISH: -- but the problem is we don't have identifiable or consistent numbers of new graduate positions where we can bring people in and so then that makes it a bit tricky when you're trying to build confidence in the student pipeline to come and work with us straight from graduation.

MR MUSTON: Why is that? Why is it that there is a less seamless path into a graduate recruitment type position for allied health than, say, nursing? Medicine is a bit different because you don't have any choice, but --

MS DOMINISH: I think comparing it to something like medicine, where, for all medical graduates they have to do an internship to get their registration, so historically, by way of sort of forced requirement, they have had to do that one year of internship to then get their registration,

and the perfect place for that to occur was always NSW Health. That has expanded over time where there are other private organisations that form part of the allocation process, where people can do their internship.

I think scale with nursing and midwifery, again, you are dealing with one discipline, or one other discipline, and you've got large numbers. So in that hierarchy of care you're always going to have room for that new grad level and then you've got the more senior ones on top.

In allied health, you might have a district like Western Sydney, you might have a large physiotherapy department and you could probably identify two new grad positions every year, but if you are out in back of Bourke somewhere, you've got a more dispersed model across the districts, and so where you might be able to allocate or have a new grad position might vary depending on who else is there and what type of work. So it is not that it can't be done, I think it is just that it has never been properly focused on with a centralised approach. I've used that word. So, yes, I definitely think that there is an opportunity to potentially consider it.

There also hasn't perhaps been a focus - I talked in my statement about things like the medical cadetship program that the Rural Doctors Network runs, and to go to those examples you have provided previously about some of our hard to fill positions, perhaps if there was new graduate positions created in areas of need that did maybe have a return of service component, that might be a good way to go, but it would need to also come with what is the scaffolding and support that you're providing those people, particularly if they are going out, again, they will be working in isolation so needing that sort of support or transition to practise.

PROFESSOR NEWTON-JOHN: I just want to reinforce the point that Ms Dominish made about the interest in working in health. I've had a number of conversations with new graduates who say their preference would always be to get a health jobs, but the on-boarding process is so long, the jobs often are advertised at the wrong time of the year. They've got big student debts to pay off and there is a private practice down the street which will employ them in a week. So that has come back a number of times of people saying it's not their preference but the realities

of the system has been that they end up working privately. So yes, I think if we can manage some of these hurdles, there is no shortage of interest in new grads in working in health, for a number of reasons that are outlined in these documents.

MR MUSTON: Taking it right back to the very start of the pipeline, to the extent that the ministry has data available at its disposal about areas of critical need - and I think you mentioned earlier radiation therapists - is there a conversation which happens between the ministry, informed by that data, and education providers such as UTS --

MS DOMINISH: Absolutely.

MR MUSTON: -- about standing up courses to produce more radiation therapists, just as an example?

MS DOMINISH: Yes, absolutely. So this is one profession that we're taking some pretty specific action on. So aside from the usual conversations we have with the deans, radiation therapy, just to put it in context, there used to be a course run by Sydney University which closed, it might have been about six or eight years ago now, so that pipeline has stopped completely. So now we only have University of Newcastle and Charles Sturt down in Wagga, and then there's a masters program running out of Monash in Melbourne.

MR MUSTON: Just pausing there, radiation therapy is different to radiography.

MS DOMINISH: Correct.

MR MUSTON: It is not taking images using radiation but it's rather administering radiation as a therapy.

MS DOMINISH: Yes. So radiation therapists operate the big linear accelerators. If any of you have undergone cancer treatment yourself or your family members, it requires a complex planning process. The person will come in and be positioned and have that treatment applied by a radiation therapist. There's no replacement workforce and we cannot run linear accelerators without radiation therapists. So it's really critical for the viability of timely access to cancer treatment for our population.

We don't have a metropolitan course anymore, and that's a significant issue, and our biggest demand comes out of Sydney and - Western Sydney, South West. So it is an interesting situation because it's a bit of reverse rural problem.

In order to tackle this, with support from the secretary, we stood up a radiation therapy action workforce group that's been running for almost six months now, and that's in partnership with the current course providers as well as radiation oncologists, our heads of radiation therapy and ministry experts and our chief allied health officer, to rapidly look at what are some immediate things we could potentially do to try and boost the pipeline, as well as attract and retain people into that profession.

Our future workforce unit, headed up by Tamara Lee, held what we called the first of - we haven't done it before - an accelerator, where we brought all stakeholders together including the private sector and universities to have a really intensive discussion to try and come up with one potential solution or action that we could focus on to try to, I suppose, unblock the pipeline in the short term. So we're working through the recommendation of that right now.

So, to your question, yes, we do, and the challenge for radiation therapy is we've got a workforce that is now extremely tired, they are working long hours. The private sector snaps up people after they've been out a couple of years and uses them, you know, obviously for services there. We have to support them to take placements, but then we've got this issue of there's no workforce to back-fill the holes and so how do we get students in on placement that we desperately need to employ when they are graduating.

So we've sort of got the puzzle pieces. How do we keep everyone afloat while we're trying to build that pipeline? Certainly one recommendation has been absolutely supporting the existing staff and the students with dedicated facilitators and educators so the staff can keep running the services and help with the placements.

Then the other opportunity we've looked at is the current allied health award doesn't allow employment of

radiation therapy assistants, so we're negotiating with the Health Services Union to have that classification put in. Ideally if people had an offer of being able to work as an allied health assistant while they were training, particularly in Sydney, and then if positions are available, which they are, they can apply for those on graduation.

The new thing that has come into the market is the course in Victoria, which is a two-year masters degree. So to boost the pipeline we're going to need to try and target people who have done things like science degrees or other degrees and haven't really worked out what they want to do but that might be really keen to become a radiation therapist - so thinking outside of the box. And any other suggestions that anyone has would be welcome.

MR MUSTON: Using that as an example, your institution, UTS, does not currently offer a course in radiation therapy.

PROFESSOR NEWTON-JOHN: No.

MR MUSTON: Has your institution been part of the discussion around how to solve the radiation therapy crisis?

PROFESSOR NEWTON-JOHN: Not radiation therapy, no. We've actually looked at sonography and ultrasound as a potential new course but not radiation therapy.

MR MUSTON: Using sonography as an example, did you end up standing up a course in sonography?

PROFESSOR NEWTON-JOHN: We didn't, no.

MR MUSTON: Why not?

PROFESSOR NEWTON-JOHN: Primarily because of the number of hours of supervised placement time that that accreditation body requires means that students essentially need to be employed three days a week in order to meet the number of hours requisite for the qualification and the feeling initially was that that would require such an industry collaboration, in terms of that being a viable option, that it wasn't something we were able to do straight up.

MR MUSTON: Because you weren't confident that someone out there in the industry would be able to guarantee sufficient employed positions for you to have enough people able to do your course?

PROFESSOR NEWTON-JOHN: Indeed, and a very generous employer to release that staff member for their two days a week on their course whilst they're not performing in the - you know, seeing patients as part of the organisation they're working for.

MR MUSTON: In the allied health space, would it be right to assume that the particular requirements in terms of that practical component of the course would vary from one discipline to another? So sonography sounds as though it is one that has a high level of practical involvement, whereas perhaps physiotherapy or occupational therapy might not require quite the same amount of face-to-face.

PROFESSOR NEWTON-JOHN: Yes, they vary in terms of the number of hours, in terms of the diversity of placement, in terms of the qualifications of the supervisor, you know, they all have their own sort of processes.

MR MUSTON: Having regard to the relatively thin market of placements and potential candidates participating in those placements across each of the different allied health disciplines when compared with, say, nursing or medicine, is there scope for a greater level of centralisation of that allied health placement/practical education component being delivered through the public health system? That is, unlike the current arrangement which seems to be brokering of a placement arrangement between a facility or an individual clinician within a facility and an institution, is there scope for all of those different allied health professions to be grouped together under the banner of, say, an adequately funded HETI to distribute those placements - collect and distribute those placements in a way that works for the system best?

MR GRIFFITHS: I think yes, and it is different to the conversation we had this morning with nurses, because I think there's probably greater need for centralisation for allied health given the challenges we've just talked about, the fractionated appointments, et cetera. Again, we would be open to a conversation about it, but the same thing as this morning applies for allied health. There are

arrangements with education providers and organisations that would be challenged by us centrally dispersing or distributing students across the system. So we would need to work through that as a collective in order to be able to do that at a more centralised level.

MR MUSTON: Can I just test that with you, and I will come to you, Ms Dominish, in a minute, and perhaps, Professor Anderson, tell me if you have a view on this, but I understand the position that is being put is that there are some longstanding arrangements between institutions and particular LHDs or facilities around the placements with students from one facility going to an institution. Is the point that if you were to centralise it tomorrow and sever all of those relationships and try and build a new centralised process for distributing those placements, that there would be a great disruption of a system which, whilst not perfect, is at least providing a service, and that perhaps what would be needed is a period of transition where you moved into a central system which, in and of itself, possibly took into account existing relationships, many of which might be geographical and have other logical bases which sit behind them? That was a very long question.

PROFESSOR ANDERSON: I think for us, partnerships are key. We don't have courses without partnerships with clinical agency. We work in any and every way we can to try to get the best clinical placements for the number of students that we have across all of the health disciplines.

I would just say also that most of our allied health are actually postgraduate courses, so, you know, post-registration, so they all come in with a degree and then they will do the various allied health, except for the bachelor of psychology. So all of ours are in that way anyway.

We would work with NSW Health in any way that they would see would work for allied health students in their placements, whether that was a central model like we see in Queensland or a model that exists at the moment. We would certainly, just from an education perspective, really would like to - we know that the clinical placement model was put in place in 2013, I believe, so, you know, we wonder if there might be an opportunity to look at how we could - I think we have identified with allied health it can

sometimes mean the placements are fairly, what's the word, opportunistic, so whether that could be a model that NSW Health could look at, we would support, however they choose to do that.

MR MUSTON: Ms Dominish?

MS DOMINISH: I think I'll just park the issue of the allocating the placements for a second, but acknowledging that there has already been commentary around if that was occurring, it would need to be married with a recognition of the required resourcing to support that to occur and in a more transparent and equitable way across the state.

What has occurred in Queensland, which you may already be aware of, was back in, I think, 2014 they had a huge review of the clinical training landscape in response to a number of incidents, and in the allied health space through an enterprise bargaining agreement there was a significant injection - I think 164 FTE - of educators across the state to be able to immediately uplift clinical placement capacity because they'd had a very significant increase in the number of universities and courses that had come on board in Queensland in a short period of time.

What they did, from my understanding, was they divvied that up based on the scale and size of the allied health workforce. For example, with physiotherapy, they had a state level person that would provide guidance consistency and leadership around clinical education for physiotherapy with locally based student educators around the state, so there was a bit of, like, a community of practice and network but it was connected to a central strategy and standard.

For the smaller professions like podiatry, I think, child life therapy, et cetera, it was either fractional appointments or people that were allocated regions, or if they were really tiny, one person for the state. So in the examples you were providing, say we needed a placement for child life therapy, that might need to be something that is done with a statewide view as opposed to the bigger professions like physio that are well established, have large departments and really close relationships with the universities.

I think it is a difficult situation because the

relationships are key, but as I said earlier, where's the line between the strategic and the operational and the actual execution of the allocation of the placements? I think that's something we're still trying to unpack.

MR MUSTON: Is a potential way of dealing with it which quarantines some of the clinical educators from budgetary pressures which might see them as being, in a very challenging budgetary environment, the first to go, providing a budget to, say, a central organisation like HETI, charged hypothetically with the responsibility of managing this placement scheme and coordinating centrally with all of the universities about the placement, but equally having within its budget this education component or the clinical educator support component, to use your example, very small specialisation, there might be only one in the state; a bigger example that actually might need one or more than one in each LHD, it comes down to HETI with its budget - I say "HETI", but a HETI-like organisation - to deliver to ensure that that support is funded and provided, and also to do it in a way which is well coordinated with the distribution of placements across the system, managed centrally to make sure as many placements as can be found in areas of need can be found and coordinated with the universities who, of course, will have their own push and pull factors around different connections that they might have with different LHDs?

MS DOMINISH: Potentially, and I think some of the evidence that has come out of the Queensland experience - there are two papers and I'm happy to send them to you via Crown solicitors - where they did a bit of a preliminary evaluation of the efficacy of the model and its ability to increase the placement capacity and then they re-looked at that and published again in 2020 and it was shown that even when they had challenges around staffing, they were able to maintain that capacity through the investment in the educators but also the statewide networked approach. That's on the side of the student education perspective.

I think there would still need to be recognition of the relationships and the role of the student educators in those home bases and the connectivity to the clinical teams and services and, you know, OT managers or whatever it is. But I think that could have merit, yes.

MR MUSTON: Viewing this as yet half finished jigsaw from

the university's side of the table, do you have any comments on it? Do you think that could potentially work, a centralised model which provides the clinical educators through a central body and potentially funded through contributions made by the universities toward the placements?

PROFESSOR ANDERSON: I think a consideration of that role in the model could be considered as part of the review, and, you know, part of our central UTS recommendation was a review of the clinical practice model if possible. So I think that would be something that you would want to consider.

MR MUSTON: So when you say "a review of the clinical practice model", will they vary from the --

PROFESSOR ANDERSON: The clinical placement.

MR MUSTON: Oh, the process.

PROFESSOR ANDERSON: Sorry, yes.

MR MUSTON: Can I ask, perhaps starting with you, Professor Newton-John, to maybe conceptualise what you see would be a pathway for a student that might best place a student in an area of allied health need in a situation of perhaps a rural LHD or a rural facility, where that need was greatest. Sort of talking through it from the student's point of view are you able to conceptualise a path - and Professor Anderson, jump in as well - that you think would work in terms of funnelling that potential workforce into the areas where it's needed?

PROFESSOR NEWTON-JOHN: So again I think to the point I made earlier, a lot of newly qualified allied health students are interested in working in health, and whether it's rural or it's metropolitan, it's the fact of working in a hospital and a hospital environment and the potential benefits that can come from that, which we've talked about, which is the attraction. So my sense is that the pathway would be along the lines of ensuring that there was adequate supervision, that they weren't left on their own as a sole practitioner, newly qualified, managing all sorts of complex cases with no-one to support them. So ensuring that if it was a rural position, that there were at least senior clinicians that they could be supported by.

I think it's mentioned too somewhere in the documents here, whether there was financial incentive to assist them with perhaps, you know, moving to a new location. A lot of our students, although it's a graduate entry school, return to live with their parents in order to do the training because they can't afford to be working and studying full time and being on placements for the protracted periods of time that they can't work.

So for that sort of student cohort to move out of the metropolitan area, if there was a financial support to do that, I'm sure that would be very welcome. But a large part of it, my sense is, is that they would not be kind of - you know, that's a time where lots of supervision and ongoing clinical professional development is critical, and as long as those supports were in place, I think those rural positions would be very attractive to a lot of students, or new graduates.

MR MUSTON: In terms of placements at that early stage of the pipeline, do you think placement scholarships and perhaps even cadetships or indentured scholarships that required a period of return service would work?

PROFESSOR NEWTON-JOHN: In terms of yes, whilst they are still training, absolutely they would. Because at the moment for our students if they want to do a placement in Melbourne, we support them to do it or they support themselves to do it, and not every student can do that, of course. It's not equitable in any way at the moment, so if there was an opportunity whilst they are training to do a placement and be supported to do it remotely, they would - you know, the feedback is they all want to do it.

MR MUSTON: Are cadetships and indentured scholarships something that the ministry has looked at in terms of dealing with areas of particular need within the allied health workforce?

MR GRIFFITHS: Yes, and scholarships and stipends and grants. We've got a range for allied health. The challenge really is because there aren't enough students, the metro is too attractive. So we've got a range - and we advertise scholarships and cadetships and grants, and we give them out, but for a lot of students, particularly in the post-grad environment, it is hard if they're in a

particular stage of their life where doing a placement rurally is a disruptor to their family. So there are those sorts of very practical things, and while there are not enough of the student body, they can basically pick where they want to go.

MR MUSTON: And that contributes to the maldistribution, in part because metropolitan might be seen as more desirable, and in part because their training and placements have, no doubt, been predominantly within the metropolitan setting --

MR GRIFFITHS: Yes.

MR MUSTON: -- which tends to funnel them in that direction, anyway

MR GRIFFITHS: Yes, and metro is short as well.

MS DOMINISH: Then we still have the issue that I referred to earlier of the lack of new graduate appropriate roles across NSW Health. So even if they want to, for example work somewhere, there may not be a new graduate position available at the right time there. So it might come up in June or July, but they're already looking for a job in January. So that timing - and that's where perhaps a more considered approach around cadetships that are paired with return of service, obviously still in line with recruitment and selection policy - that's something we haven't done but that would require obviously a financial investment, but partnership and cooperation with the local health districts that would see that as being of value.

MR MUSTON: This is a genuine question: would it really require a significant financial contribution or investment in circumstances where all that it would be doing, theoretically, is filling a role that you might otherwise - that is funded and you would otherwise be wanting to fill, albeit doing so preemptively rather than after and perhaps long after the vacancy has become available?

MR GRIFFITHS: But often the role isn't filled.

MR MUSTON: It's not filled?

MR GRIFFITHS: No.

MS DOMINISH: So it is a bit of coordination and organising and getting people on that cycle, getting districts and departments on that cycle of, you know, come January we're recruiting to these roles, rather than just going with the flow, but also recognition from chief executives in the system that this is the program we're running, because they might decide that they're holding on to vacancies or recruitment due to budget issues, or there might be other factors at play. So yes.

MR GRIFFITHS: There is real opportunity, I think, and it all comes down to finance. I have put in my statement that there are approaches to workforce replenishment that have been used in other areas of government and other jurisdictions that have been really successful at targeting areas of identified shortage, but it requires a significant investment.

The one that I will refer to specifically is one ran in SA Water for quite a while for engineering shortages, where they effectively over-established. They filled over-establishment a couple of years out from the time of someone notifying that they were intending to retire, so the exiting workforce would approach the organisation, a grad would come in behind that person full time and shadow them. So there are things like that --

THE COMMISSIONER: Did that work?

MR GRIFFITHS: It did. It has been very successful.

THE COMMISSIONER: It's an ongoing program there, is it?

MR GRIFFITHS: I'm not sure if they are running it now but it was running at the time. There was a critical engineering shortage.

THE COMMISSIONER: It achieved its purpose.

MR GRIFFITHS: Yes.

MR MUSTON: The investment is obviously you are, for a time, paying two people to do the one job --

MR GRIFFITHS: Correct.

MR MUSTON: -- albeit one relatively junior person.

MR GRIFFITHS: That's right, for a defined period and usually it was one or two years. But what it did was it shored up supply for that area of shortage.

There is an opportunity in these sorts of areas for us to explore that, but it all comes down to whether we've got capacity within our budget.

MR MUSTON: Could that opportunity be combined with the placements, though? Within the allied health space, say, your two years worth of shadowing, if it were two years, at least one of them, would it be possible for that to be happening at a relatively cost neutral --

MR GRIFFITHS: The reason that I raise it in that context was along those lines, that if you had that sort of investment, that would then open up places where you know that you've got some certainty for that student pipeline. So you can run your student placements knowing that there is going to be a vacancy as a result of that replenishment strategy.

MR MUSTON: I used the term "cost neutral" earlier, and I'm not wanting to discount the cost of the training component, but a placement which was happening in circumstances where the student was attending, observing, being trained without being employed, would obviously potentially give you some of that overlap, but there would also possibly be some scope to employ someone as an assistant in allied health, they could take that role through that period whilst they're training, might assist to cover the cost of being out in our Brewarrina situation, and at the end of which may be indentured, maybe just because that's the way the pipeline would be steering them, the candidate ends up working in that area of need. That's the theory?

MR GRIFFITHS: Yes.

MR MUSTON: From the perspective of someone who engages regularly with students, do you see that, Professor Newton-John, as being something potentially desirable?

PROFESSOR NEWTON-JOHN: Yes, absolutely. For the students who are interested in working in those areas, it would be

really kind of secure and, I guess, you know, for them to make that investment to move away from home or to go and do that, to know the potential of moving into a position at the end of it would be very attractive, yes.

MR MUSTON: In terms of if there was the assistant in allied health type employment as part of it - let's explore in a minute whether that could be all of the placement, whether it should be broken up into part employment and part just pure observation - that presumably would assist to cover some of the financial challenges associated with placements in rural and remote areas?

PROFESSOR NEWTON-JOHN: We don't have assistant in allied health positions. It's not a pathway that we have, but I guess you guys are referring to employing a student in that level position.

MR GRIFFITHS: That allied health assistant issue still is challenged by metro versus rural sort of saturation. You would want an assistant in allied health, for example, to be working while they study, to get the most out of that placement, but that's only going to be possible if they're working in an area that's within a commutable distance from their study, or we design a course so that there's a way of that being excused from on-campus attendance and they can relocate for a period in some of the other hospitals.

But again, it does come down to that issue of student poverty. I mean, that's a way of overcoming it, but the student placement thing is then limited by that as well. It's an imposition for the student.

MR MUSTON: In terms of the university side of that, is there, at least within your institution, a willingness or an ability to be more flexible, perhaps, than historically institutions have been about the way in which education in an allied health discipline is delivered, say to facilitate three months, six months placed in a rural hospital working as an assistant in allied health doing some placement, perhaps receiving some remote education and then - no doubt you guys would go a lot better than me about how else it could be done - you could perhaps have them coming back for some residential components? Is that the sort of thing that your institution is exploring?

PROFESSOR ANDERSON: Definitely. We have a lot of hybrid

learning, a lot of virtual. We're able to - we're looking at artificial intelligence, for example, for OSCEs, for clinical placements, for virtual reality. So I think there would be certainly an ability for us to work in that capacity, and I would say that what our research has found is if you attract students who are actually from a rural area and they might aspire to come to a metropolitan university, if you can give them a placement back in the rural area or close to where they came from, they're much more likely to then seek employment and be a more long-term employee when they go back. So I think that, as you are talking, we would certainly welcome the opportunity and be quite flexible in being able to support initiatives if the New South Wales Government came up with those.

MR GRIFFITHS: Can I just add, the other thing, in terms of the assistant in allied health - and it won't so much be for UTS because you've got post-grad entry, but for the other universities where they have undergraduate entry, there is no articulation from the certificate that they do through the vocational training institutes for the allied health assistants towards a degree. It would be really helpful if we were able to influence - and I know that's not necessarily just the university, that will also be the councils and the accredited bodies, but I think that's a big omission at the moment. We don't have that articulated pathway to move from vocational education into the undergraduate degrees.

If we could get that, I think there would be a lot more - there would be more willingness for local health districts to establish assistants in allied health, knowing that it's leading to a pathway to a registered professional.

MR MUSTON: Is that to be contrasted with nursing, where I think, as we understand it, after a period of your nursing sturdy, either through vocational training whilst you're finishing your school, or alternatively through a tertiary education when you finish your first year of your registered nurse's degree or your nursing degree, you then acquire a formal qualification as an assistant in nursing. Have I understood that correctly?

PROFESSOR ANDERSON: Certainly with the programs that we have with assistants in nursing who are doing it through the bachelor of nursing with our local health districts,

no, that doesn't transfer. So it's not a replacement of the clinical practice, which they still need to do, because it is at a very different level. However, there are in nursing, you know, the VOC ED through the enrolled nurse, et cetera, that that goes through.

I think I read in here a thought about would there be, like, an RN qualifying going through? I guess that idea that you are talking about would probably work across the health professionals, whether it was nursing or allied health. It could be something that could really be an opportunity, I think.

MR MUSTON: Am I right in my understanding that with a bachelor's degree as part of this nursing program that you've got where someone is employed as an assistant in nursing after their first year of study, the employment as an assistant in nursing is no substitute for the placement, which is a different level of experience which requires them to observe and participate in things which sit above the ordinary duties of an assistant in nursing?

PROFESSOR ANDERSON: Correct.

MR MUSTON: But at the end of their first year of study they do come away with a piece of paper which qualifies them to be employed as an assistant in nursing; is that right?

MR GRIFFITHS: It's not so much a piece of paper. That's a policy decision from NSW Health that we have - we have taken a decision that students at the second year can move in and work as an assistant in nursing.

Through the vocational education pathway, though, you can articulate all the way through. So you can start out as an assistant in nursing, which will count towards your enrolled nursing course, which will then count towards your RN course. So you can keep studying without necessarily starting from scratch every time.

That's not possible in allied health at the moment and that I think would be very attractive to people, particularly some of our allied health bachelor programs are very high ATARs, and they are - because they are high demand. So it locks out a lot of people who would otherwise be amazing allied health practitioners, so having

a vocational pathway would be of benefit for us. I think we probably would have a large pool that would move through the system and we could use them differently because, as I said, I think there would be local health districts that would be a lot more prepared to establish an assistant role if they know it's going to articulate to a registered professional.

MR MUSTON: Commissioner, I know you had some questions --

MS DOMINISH: Just to add to that, so I think where we're coming from with this is so to be employed as an allied health assistant you can walk in off the street and get on-the-job training, or you can do your Cert III or Cert IV. So I think the angle that has been coming from here is say you have someone who is interested in allied health, they do their Cert IV and they work as an allied health assistant in a designated role that is a permanent role or whatever that the system needs, and then they decide, "Actually, I'd really like to be a podiatrist. Can I use that Cert IV as RPL or entry to get into an undergraduate degree as a podiatrist?" That's absolutely something we're trying to look at for the Aboriginal workforce, because we desperately need Aboriginal podiatrists, as opposed to an undergraduate, already studying, who is employed in an AHA role who we know is hopefully going to graduate after that.

MR MUSTON: And if we could get the recruitment lined up with the point at which they graduate, you would hope that the chances of securing them as an employee of the public health system might be improved. -

MR GRIFFITHS: No argument from us that we need to be into the degree students earlier and offering jobs earlier.

MR MUSTON: I think, Commissioner, you said before lunch that you had some questions --

THE COMMISSIONER: On a more general topic.

MR MUSTON: I'm just mindful of the time, I'm happy for you to use the time now --

THE COMMISSIONER: Are you switching topics?

MR MUSTON: I was going to, yes.

THE COMMISSIONER: Can I ask you, firstly, Mr Griffiths, I wanted to give you an opportunity to expand on a couple of things in your most recent statement, if you have it in front of you. It is the section commencing at paragraph 110 which is identifying current demand service areas. Just tell me when you have that.

MR GRIFFITHS: Yes.

THE COMMISSIONER: In paragraph 111 you tell us that NSW Health focuses too strongly on adapting models of care to the current workforce and the way it currently works, rather than building workforce for delivery of new models of care. What would you like me to understand more fully about that?

MR GRIFFITHS: So at the moment, we work within the domains of the workforce that we have, and so we will look - we will innovate but we innovate within that existing workforce.

What we don't do enough is to look at what workforce we need to create around what a model of care should look like, so that would be - at the moment we know we've got doctors, nurses, allied health professionals, scientists, and we build the model of care around that. If we look at moving to future demand, we really need to just be looking at service demand and then creating workforce to be able to provide that service. And that might be a hybrid of some of those.

I talk in my statement about moving something a little more contemporary in terms of planning for skills rather than just planning for disciplines.

THE COMMISSIONER: You mention that, I think later, in 119, which I think is linked to what you are saying in this section.

MR GRIFFITHS: That's right.

THE COMMISSIONER: Should I understand it - please tell me if I'm completely misunderstanding this. Don't hesitate. We will no doubt always need a workforce of, whether it's clinicians, allied health, et cetera, to deal with the traumatic injuries we have and also diseases that require

hospitalisation, so all that acute care stuff --

MR GRIFFITHS: Yes.

THE COMMISSIONER: -- but are you driving at looking at creating a workforce that is more aimed at achieving the health outcomes we might want for the population - that is, do we want the population to be healthier, do we want to decrease the period of years that people live in chronic disease, do we want to be able to provide more care where it's appropriate outside of a hospital setting and in a home or a community setting? Is that the sort of thing you're looking at generally in that part of your report?

MR GRIFFITHS: Yes.

THE COMMISSIONER: So I'm not misunderstanding that?

MR GRIFFITHS: No, no, that's correct.

MR MUSTON: Can I ask a question about that quickly.

THE COMMISSIONER: Of course, you can, yes.

MR MUSTON: I gather from that that what you have in mind is looking at, first of all, identifying the outcome that you want in terms of public health outcome for the community; then identifying a service which might best, in the eyes of those who know, achieve that outcome; and then looking at that and saying, "Well, what mix of professionals and resources do we need in order to deliver that service?"

MR GRIFFITHS: Yes.

MR MUSTON: Next step, obviously what's it going to cost to deliver that service, and that would then inform decisions around the funding of LHDs to deliver the array of services that, through that process, have been identified. Is that to be contrasted with a situation where - what I understand you to be saying about the current situation, which is a little bit more focused on how many doctors do we need FTE-wise, how many nurses do we need FTE-wise, et cetera?

MR GRIFFITHS: Yes, and I don't know that it necessarily needs to be contrasted with that, because that can be the

end point overlay. But what we need to understand is as disease profile changes, as technology comes in, as societal demands change, is the health system changing its workforce to meet all of those things? You know, if you step forward into the future, we may not necessarily need the number of doctors we've got, for example, because there might be technology that actually does a lot of the diagnostics. So the workforce demand then becomes more of a technician rather than a diagnostic professional.

They are the things that at the moment we do some thinking about but we don't bring them about enough, because we're locked in to the workforce and the workforce profiles that we've got. So a lot of our workforce profiles are retrofitted into: well, we've got this many doctors, the doctors can work to this scope, or the nurses can work to this scope, and so we create a service profile that allows us to provide that service, but it may not be the ideal make-up. So that's what I'm getting at with that.

Then if you knew what the missing category or classification was, then you would do the next overlay, which is, well, how many of them do we need and at what point? Like, where do the existing workforces complement the skill that would be required with that workforce?

THE COMMISSIONER: Looking at that big picture area of the workforce that might be needed to achieve desirable outcomes, one just being improve population health, and, two, I guess we don't know, but let's hope that might cause a decrease in the growth of the costs of providing healthcare services, public healthcare services. NSW Health or any health department can't do that on its own, though; it's related to other activities and departments of government, for example, housing, education, all of those things need to be linked together to achieve those more desirable outcomes that we've just been talking about in terms of population health and maybe reduced healthcare costs.

MR GRIFFITHS: That's right. All of those things you've mentioned there are determinants of health. Even to bring about any sort of change, the other stakeholders like my colleagues at the table here, they have to be in the conversation as well because we have to be redesigning.

THE COMMISSIONER: Yes. Okay.

MR MUSTON: Just while we're on that topic, in terms of that conversation between the ministry and training organisations like UTS, what, if anything, do you think could be improved in terms of facilitating that high level of collaboration between the two different important components of the training pathway?

MR GRIFFITHS: To be honest, I think allied health is probably more advanced in this than the other disciplines, because we are starting that conversation about how to redesign the student experience. So there's been some really good conversations with the allied health deans and they've been very willing to work with us around looking at a different experience.

We've come to the table knowing that everyone at that table, if we design something that is a new and different student experience, we're all going to have to be doing something different, and we have enormous cooperation from the allied health teams, they're a great group to work with, actually. I think we're already starting some of that conversation but it's going to be a slow burn, I think, because of the complexity of some of the arrangements.

MS DOMINISH: I think it's complex, but I think we are at a point in time where we need to have a conversation, because it's critical to our future ability to provide services and to have a viable environment for ongoing confidence in clinical placements and quality placements.

MR MUSTON: On the university side, do either of you see ways that some of this complexity might be cut through efficiently to bring about some reform in this area?

PROFESSOR NEWTON-JOHN: I think to Mr Griffiths' point, the fact that we are starting these conversations now and recognising that ultimately we all have the same goals, it's absolutely in all of our interests to solve this, because our new graduates become the employees that you guys will be managing down the track, and so the cycle goes around. You know, it's a complex set of contingencies to manage, and as you change a little dial here it's going to change something else there, and that needs to be constantly kept front of mind.

But I think there is an absolutely willingness on the university side to be as flexible and as accommodating and as innovative as we can be, bearing in mind I think the other thing we need to recognise is there are accreditation bodies sitting across all of these disciplines which have some influence over how we train and to the extent that we train, but that notwithstanding, there is an absolute imperative for all of us to find solutions. So I think that's a pretty good starting point.

MR MUSTON: In relation to that, particularly in some of the rural and more remote areas we've heard about the fractional appointments of allied health professionals and the challenges that that raises in terms of placements and placement supervision. Is there scope for a collaboration between educational institutions, the public health system and private providers to deliver a placement experience which utilises both public and the private system in a way that maximises the experience for the student but equally increases the possibility that a student who might be doing part of that placement through the public health system, albeit supervised perhaps remotely or by a private practitioner in a town, is incentivised to move into the public health system when they get their graduate job or are looking for their graduate job?

PROFESSOR NEWTON-JOHN: Certainly from the university side there is and, in fact, we do do this sometimes. As we said, there's such a shortage, sometimes it is stitching together some hours here and some days there. But yes, you know, as long as the student is getting the appropriate level of supervision, where it's coming from, sometimes that diversity is a great thing for the student experience. So certainly from our side, yes.

MR MUSTON: Accepting that having people stitched together in the NDIS sector, for example, in a way might be pushing them away from the public system unless you can nimbly snatch them up as graduates, is there a process within the ministry for helping facilitate this stitching-together process or is that part of the work to be done?

MR GRIFFITHS: Probably part of the work that needs to be done. Given the fact that there is a bit of a disparity in terms of pay rates in the private sector versus the public sector with a lot of the allied health disciplines, I would

probably prefer to partner with NGOs who tend to replicate our pay rates. So I think we would probably lose less in doing it that way.

MR MUSTON: When you say "NGOs", do you have in mind --

MR GRIFFITHS: Non government organisations, some of which we fund.

MR MUSTON: -- organisations like Marathon Health, for example?

MR GRIFFITHS: Sorry?

MR MUSTON: Organisations like Marathon Health, for example?

MS DOMINISH: They are an NDIS provider but they also do, I think, some funded work through the government.

MR GRIFFITHS: I'm probably thinking more of some of the organisations who work off government funding in the non-government sector, though, so some of the mental health providers, where there are some cost imperatives with them, so we would probably be more of an attractive partnership, I would think, rather than the private organisations.

We would be willing to really look at all of those sectors, though, and I said this morning that it is important that private hospitals come to the table with some of this. The thing with allied health, the difference with allied health, is that some of the private partners aren't hospitals, they're private businesses who pay significantly more than what we are able to pay.

MS DOMINISH: I think for it to be a success it would be very dependent on the local relationships in that location, and I know there are some districts that do that really well, and the way that that district works with those providers in general, I think that would be critical for the success of the arrangement and the experience of the student, because you could end up in a situation where it's not a pleasant experience.

MR MUSTON: Does that suggest that to the extent that that work is done, it's perhaps work that, whilst perhaps facilitated from the centre, would be better executed in a

devolved way on the ground in those LHDs where the particular relationships are a little bit better known?

MS DOMINISH: I think so. I think you could set some rules or standards or guidelines, but the actual putting that together would rely on the local relationships, agreement with the CEs in the universities and the relevant other chief executives or leads of whatever those other organisations were.

MR MUSTON: Commissioner, I have no further questions for these witnesses, unless there is anything that any of you think that we haven't covered

PROFESSOR ANDERSON: I would just say also that we have clinics, university clinics, in speech and in psychology, so they're also are good opportunities for the student experience. We have some really great relationships with local health districts and that has been a really great positive. I think that we've been sort of managing like that in different local health districts and I think that's a certain way that we've been working.

MR MUSTON: Are the clinics delivered in the metro setting or are they delivered through rural and remote LHDs as well?

PROFESSOR ANDERSON: We've got both. We've got on campus and we've got telehealth clinics that are being delivered through exercise physiologists. I think one of the things we haven't talked about is the opportunity for digital health in rural and remote and being able to supervise students digitally. They really do need to understand telehealth now, which is a big component of many allied health areas, so that's a piece of the pie that I think we will put in as well.

MS DOMINISH: I just wanted to add to the commentary of the Commissioner with Richard around looking at new workforce models. I have provided a lot of evidence in my statements around the different models that we're currently working on, both for allied health but also paramedicine and Aboriginal health practitioners, and I think - I won't rehash it, but there was quite a lot of evidence provided by Jill Wong, who is the director of allied health up at Mid North Coast, around the tension between, like, yes, we are responsible for a lot of the acute services, but if we

don't do other things in that intermediate or corridor space, where there's an impact on flows into the hospital or preventing people from coming in, we're going to cop it as a result of that. So some of the models, like the rapid assessment intervention and discharge in the emergency department, the QuART model, which is the quick access response team in the community, and the trial we're doing around paramedics in emergency departments and hospital in the home and rapid access, I think are really promising, and the work the ministry is doing to test and evaluate those pilots with a view to statewide scaling I think is an opportunity for us to accelerate some of that work, and then keeping our university partners informed in the different ways that professionals are working and scopes of practice into the future, so that that can be considered in undergraduate contexts.

THE COMMISSIONER: Sure. Can I ask you one unrelated question.

MS DOMINISH: Sure.

THE COMMISSIONER: It is minor, but I just want to make sure I haven't misunderstood you. In your most recent statement, Ms Dominish, if you could go to paragraph 9, you mention there there is no universal definition of "scope of practice" in Australia, nor any universal agreement regarding what "working at the top of one's scope of practice" means. Should I understand - there's a very general definition given in Professor Cormack's two issues papers, but I assume you are talking about the problem that he identifies, that there are professions that haven't outlined what they mean by "scope of practice" for their profession and he's encouraging, for those that haven't done that, a facilitation of that process. Is that the problem you are identifying there or something different?

MS DOMINISH: Yes, that is, and then the other part of that is the terminology that each of those professions use to describe "scope of practice".

THE COMMISSIONER: Which may not be consistent.

MS DOMINISH: Correct. Then when you're trying to have a conversation about a multidisciplinary model of care, everyone is talking about different things. The work we're doing in New South Wales, which I've also mentioned in my

statement, is to start that high-level conversation as a jurisdiction: what does it mean to us in the way we practise and the way we set policy and the way we use language across the professions in the state? So if nursing are talking about it and allied health is, and medicine, we're coming from a consistent way of talking about it. So - yes.

THE COMMISSIONER: All right. Thank you. Is there anything out of that?

MR MUSTON: No.

THE COMMISSIONER: Mr Cheney, I forgot to ask you whether you wanted to ask any questions of the two prior witnesses. I assume the answer is "No", because you didn't jump up, but would you like to ask anything of these witnesses?

MR CHENEY: No, thanks, Commissioner.

THE COMMISSIONER: Thanks. That's it? All right.

To all four of you, thank you so much for your time. We're very grateful, and also for the work that went into your statements, too, which are very helpful. Thank you for that, and to those assisting you.

<THE WITNESSES WITHDREW

THE COMMISSIONER: Do we adjourn until 2 o'clock tomorrow?

MR MUSTON: Yes.

THE COMMISSIONER: All right. We will adjourn until 2 o'clock tomorrow.

AT 3.36PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED TO TUESDAY, 15 OCTOBER 2024 AT 2PM

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