

**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

1 THE COMMISSIONER: Just before we start, because it is
2 a new hearing block, can I acknowledge the Gadigal people
3 of the Eora Nation, the traditional owners of the land on
4 which we gather today, and pay my respects to their elders
5 past, present and emerging.
6

7 MR MUSTON: The first thing I was going to raise before we
8 come to the evidence, I understand that an affidavit's been
9 provided by the ministry in relation to some aspects of
10 timing. I don't know whether Mr Chiu of senior counsel
11 would like to come and address that briefly before we get
12 going.
13

14 THE COMMISSIONER: Sure, yes.
15

16 MR CHIU: Commissioner, if you don't mind, I have the
17 honour to announce that I have been appointed as senior
18 counsel for the State of New South Wales, taking rank of
19 precedence next after my learned friend Fionnuala Marie
20 Therese Simpson.
21

22 THE COMMISSIONER: Congratulations. It is very well
23 deserved. Like the answers to many of your questions,
24 I actually knew before you did. You are not meant to
25 betray confidence of these things but I can guarantee you
26 it was nearly unanimous.
27

28 MR CHIU: Thank you, Commissioner.
29

30 As for the second matter, as counsel assisting
31 alluded, an affidavit of Nigel Joseph Lyons sworn 3 October
32 2024 was provided to the Commission.
33

34 That affidavit sets out some difficulties, practical
35 difficulties, that NSW Health has in meeting a submissions
36 deadline at the end of January and respectfully seeks
37 a period of extension into February. I just thought
38 I would put that on the record formally.
39

40 THE COMMISSIONER: The only thing I will say about the
41 affidavit today is that I accept all the factual basis,
42 obviously, that is set out in the affidavit.
43

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

1 extension on the reporting date which would accommodate the
2 period of extra time that is being sought through this
3 affidavit.
4

5 I don't know what will happen there. So what is being
6 sought is to change the report date from 26 March to
7 24 April, because Easter accounts for the extra bit from
8 three weeks, on the basis that there won't be any more
9 hearings, there won't be any more evidence taken, it will
10 just enable the Inquiry team, if you were to supply what
11 you want to supply by 18 February, to properly consider and
12 include in the report your submissions and responses to
13 draft recommendations.
14

15 I don't know what the answer to that will be but if
16 the answer is "No", which is one of the possibilities,
17 I won't make a formal ruling today, but it would be very
18 difficult to accommodate the extension sought, the reason
19 being that, on the current timetable, the report goes to
20 the printers on 26 February, which would leave four
21 business days to consider Health's submissions and response
22 to draft. So we could read them but it wouldn't be
23 reflected in the report. So that's what we have done at
24 our end.
25

26 That was communicated a week ago now. Hopefully, we
27 will hear during the course of the week what the
28 government's position is on that and I will let you know
29 straightaway. Then I will still hear anything further you
30 want to put to me regarding the affidavit and the need for
31 this extra time before I make a final ruling. I'm just
32 saying if there is no extra time for the report, it is
33 going to be very difficult to accommodate.
34

35 MR CHIU: I understand. Thank you, Commissioner.
36

37 THE COMMISSIONER: Thank you.
38

39 MR MUSTON: We are embarking upon the second of our
40 workforce hearing blocks. As it is a continuation of the
41 last I won't detain us too long with any formal opening but
42 perhaps give some indications just of the proposed format.
43

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

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

3
4 They were identified in an issues paper which was
5 circulated widely and responded to by a range of interested
6 parties. What we're proposing to do during this hearing
7 block is to bring together panels, effectively in a
8 roundtable type arrangement, although as you see in front
9 of you, it is not round. We are somewhat constrained by
10 our physical environs.

11
12 The idea is by bringing together different interest
13 groups within particular subject areas we're hoping that we
14 can explore some potential solutions that they have brought
15 forward and to the extent that there are different views
16 amongst different interest groups, whether it be the
17 ministry, education providers, clinicians or industrial
18 organisations about what solutions might work, what might
19 not work, we see this as an opportunity for us, and them as
20 between themselves, to tease out some ideas and to see if
21 we can find some common ground, and to the extent there is
22 not common ground and there is difference, we will
23 understand what the difference is.

24
25 The first panel deals principally with the nursing
26 workforce and, in particular, has a focus on the education
27 of the nursing workforce and the way in which that impacts
28 on the pathway and workforce challenges, including
29 shortages and maldistribution.

30
31 The people in front of you, from your left to your
32 right, are Professor Kathleen Baird, who is the head of
33 nursing at University of Technology, Sydney; Richard
34 Griffiths, the executive director of workforce planning and
35 talent development at the ministry, who we have heard some
36 evidence from before; Michael Whaites, the general
37 assistant secretary of the NSW Nurses and Midwives
38 Association; Jacqui Cross, the New South Wales chief
39 nursing and midwifery officer, who again we heard some
40 evidence from in the first workforce hearing block; and
41 Jacqueline Dominish, from the health professionals
42 workforce within the ministry. Again, we've heard some
43 evidence from her already.

44
45 I understand that each of them is happy to take an
46 affirmation. What we were proposing is if the affirmation
47 is read once, they could each seriatim say "I do", without

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

3
4 THE COMMISSIONER: I'm happy to adopt that process.

5
6 <KATHLEEN MARION BAIRD, affirmed: [10.09am]

7
8 <RICHARD RONALD GRIFFITHS, affirmed:

9
10 <MICHAEL JOHN WHAITES, affirmed:

11
12 <JACQUELINE MARIE CROSS, affirmed:

13
14 <JACQUELINE ANNE DOMINISH, affirmed:

15
16 MR MUSTON: I might start with you, Professor Baird.
17 Could you state your full name for the record, please.

18
19 PROFESSOR BAIRD: My full name is Kathleen Marion Baird.

20
21 MR MUSTON: And you are the head of nursing at the
22 University of Technology Sydney?

23
24 PROFESSOR BAIRD: I'm the head of nursing and midwifery.

25
26 MR MUSTON: Nursing and midwifery, I'm sorry. You have
27 contributed to a statement prepared by the University of
28 Technology, Sydney?

29
30 PROFESSOR BAIRD: I have, yes.

31
32 MR MUSTON: Which is, I think, exhibit L18, Commissioner.

33
34 Insofar as you are aware, are the contents of that
35 statement true and correct?

36
37 PROFESSOR BAIRD: Yes, they are.

38
39 MR MUSTON: Moving to you, Mr Griffiths, would you state
40 your full name for the record.

41
42 MR GRIFFITHS: Richard Ronald Griffiths.

43
44 MR MUSTON: You are the executive director of the
45 workforce planning and talent development branch within the
46 ministry?

47

1 MR GRIFFITHS: Correct.
2
3 MR MUSTON: You have prepared three statements to assist
4 the Inquiry, two of which were tendered in the first
5 hearing block as H5.21 and H5.21.2, but you have prepared
6 a further statement, I think, dated 8 October 2024?
7
8 MR GRIFFITHS: I have.
9
10 MR MUSTON: You will find that, Commissioner, at
11 exhibit L7.
12
13 Insofar as you are aware, are the contents of that
14 statement true and correct?
15
16 MR GRIFFITHS: Yes.
17
18 MR MUSTON: Thank you.
19
20 Mr Whaites, could you state your full name for the
21 record.
22
23 MR WHAITES: Michael John Whaites.
24
25 MR MUSTON: You are the general assistant secretary of the
26 NSW Nurses and Midwives Association?
27
28 MR WHAITES: Correct.
29
30 MR MUSTON: You have not prepared a statement. Your
31 organisation has prepared a submission which has been
32 provided to the Commission?
33
34 MR WHAITES: Yes.
35
36 MR MUSTON: Were you involved in the preparation of that
37 submission?
38
39 MR WHAITES: Yes.
40
41 MR MUSTON: You have read the submission recently?
42
43 MR WHAITES: A significant proportion of it, yes.
44
45 MR MUSTON: That portion you have read, insofar as you are
46 aware, the contents of it are true and correct?
47

1 MR WHAITES: Yes.
2
3 MR MUSTON: Thank you.
4
5 THE COMMISSIONER: This is the submission of November
6 2023?
7
8 MR MUSTON: Yes. Sorry, I should have said that.
9
10 Ms Cross, your full name for the record, please.
11
12 MS CROSS: Jacqueline Marie Cross.
13
14 MR MUSTON: You are the chief nursing and midwifery
15 officer within the ministry?
16
17 MS CROSS: That's correct.
18
19 MR MUSTON: You prepared a statement for us dated 8 July
20 2024 which was tendered in the first workforce hearing as
21 exhibit H5.10. You haven't prepared a further statement
22 for the purposes of this?
23
24 MS CROSS: No, I haven't.
25
26 MR MUSTON: And finally, Ms Dominish.
27
28 MS DOMINISH: Yes.
29
30 MR MUSTON: Your full name for the record.
31
32 MS DOMINISH: Jacqueline Anne Dominish.
33
34 MR MUSTON: Because what is written down on my sheet of
35 paper does not make perfect grammatical sense, could you
36 tell us exactly what your role is within the ministry?
37
38 MS DOMINISH: I am the director of the health professional
39 workforce and the unit that it's responsible for.
40
41 MR MUSTON: Thank you. You prepared a statement dated
42 5 July 2024 which was tendered during the first round of
43 workforce hearings?
44
45 MS DOMINISH: Correct.
46
47 MR MUSTON: That was exhibit H5.9, Commissioner.

1
2 And you have prepared a further statement, I think,
3 dated 2 October 2024?
4

5 MS DOMINISH: Correct.
6

7 MR MUSTON: You have had an opportunity to read that
8 statement?
9

10 MS DOMINISH: Yes, I have.
11

12 MR MUSTON: Are you satisfied that the contents of it are
13 true and correct to the best of your knowledge?
14

15 MS DOMINISH: Yes, I am.
16

17 MR MUSTON: That, Commissioner, is exhibit L.1.
18

19 That's the formalities over with. Let's turn to the
20 substance.
21

22 As we understand from the evidence given to date, both
23 during the first block of workforce hearings and through
24 our regional hearings, within the nursing and midwifery
25 workforce there are two key challenges. The first is
26 a significant shortage in the midwifery workforce. Does
27 anyone have a different view to that which we have
28 tentatively formed on that issue?
29

30 MS DOMINISH: No.
31

32 MR MUSTON: Before we move off shortages, what about the
33 nursing workforce? Is there an issue with the number of
34 nurses within the workforce? We will come to their
35 distribution in a moment.
36

37 MR GRIFFITHS: Maybe if I respond. So our modelling
38 indicates that the number of graduating nurses is in line
39 with demand but that they are maldistributed. So the
40 distribution is challenged but the number leaving
41 universities is appropriate to meet demand. We've modelled
42 that through to 2040.
43

44 MR MUSTON: Ms Dominish, you wanted to add to that?
45

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

1 shortage to meet a load demand scenario in the future.

2

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

8

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

14

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

19

20 So just to make sure I've understood --

21

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

26

27 MR GRIFFITHS: Yes.

28

29 THE COMMISSIONER: Tell me what else.

30

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

39

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

41

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

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

7
8 MR GRIFFITHS: I'll just add that it does factor in any
9 sort of mandated levels of staffing. So we are adjusting
10 that, obviously, as we roll out safe staffing levels, but
11 it does factor that into the modelling.

12
13 MR MUSTON: In terms of the vacancies that Mr Whaites has
14 referred to, is that a manifestation of the maldistribution
15 that you identified earlier? I suppose question one: do
16 you agree that there are vacancies rolling forward in
17 shifts? Is that what your data shows you?

18
19 THE COMMISSIONER: And what kind? Are the vacant
20 positions still - are there agency staff, for example, in
21 that position, rather than the position actually not having
22 any human being providing the healthcare services?

23
24 MR GRIFFITHS: It is a very good question, Commissioner.
25 I think in my tranche 1 evidence, I talked about some of
26 the challenges of getting that level of visibility as to
27 whether or not we do have a snapshot of vacancies that are
28 unfilled. The vast majority of our vacancies are filled in
29 some way, either with increasing part-time hours, using
30 overtime or using premium labour through agencies.

31
32 There will always be vacancies. In an organisation of
33 180,000, you are going to have, at any point in time,
34 several thousand vacancies with a turnover - a healthy
35 turnover - and our turnover is sitting at about
36 13 per cent. So there is going to be some churn in the
37 workforce.

38
39 I think I mentioned in the first tranche, while our
40 turnover is at 13 per cent, we only lose, in terms of
41 actual attrition, about 6.6 per cent from the health
42 system. The rest of that is movement through the health
43 system, which does obviously generate some vacancy as
44 people move around. We're not necessarily losing them to
45 the health system.

46
47 THE COMMISSIONER: It is my fault from distracting you,

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

5
6 MR GRIFFITHS: Yes, apologies, I didn't go back to that.
7 Yes, it is.

8
9 Obviously the maldistribution does cause us some
10 challenges in areas where it is not as easy to recruit, and
11 so the lived experience of people in those units is
12 obviously felt more significantly as well, because one
13 vacancy in a small facility is a significant impact, as
14 compared to a metro, where you are going to have thousands
15 of nurses.

16
17 So, yes, it is; in relation to your question, it is
18 a manifestation from the maldistribution.

19
20 MR MUSTON: Would it be right just to summarise these
21 challenges - first, significant shortage in the midwife
22 workforce; second, significant shortages in the enrolled
23 nurse workforce; and, thirdly, maldistribution of the
24 entire nursing and midwifery workforce, particularly in -
25 well, leading to challenges in filling vacancies in rural
26 and remote settings?

27
28 Does anyone want to add or elaborate on that as
29 a series of key workforce challenges within the nursing
30 workforce? Are there any others that any you can think of
31 as key challenges which are causing problems in terms of
32 the nursing workforce and filling vacancies, getting people
33 into the areas that they need to be in?

34
35 MR GRIFFITHS: If I may, one of the other challenges is a
36 fairly rigid use of registered nurses. There is an
37 opportunity for us to really look at models of care that
38 utilise other classifications of nurses, but our industrial
39 arrangements limit us to requiring a certain number or
40 ratio of registered nurses to patients.

41
42 I won't get into the union's argument around that,
43 because obviously they're very passionate about the
44 importance of that, but that does make it very difficult in
45 some of those areas where you're supply challenged in terms
46 of registered nurses, where we could safely utilise other
47 models of care but we're prohibited from doing it because

1 of the industrial arrangements.

2

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

13

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

22

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

28

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

34

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

37

38 MR MUSTON: Let's deal with it now.

39

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

42

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

1 health districts there are examples of that in different
2 areas as well. So it is about how we allocate the care and
3 come together to provide that care as well.
4

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

10
11 MR MUSTON: Ms Dominish?

12
13 MS DOMINISH: I will just make one comment and again we
14 might get into the detail about this later, but all models
15 of care - in this case around nursing models of care - need
16 to be responsive and adaptable to the local context and the
17 patient, I suppose, profile that is coming in to or being
18 serviced in those communities. So whether it's in that
19 population or in that clinical area.
20

21 So there is a challenge by having a fixed, rigid
22 method of saying, "This is the way you must staff
23 something", that doesn't necessarily account for the
24 changing needs of the patient population and the way in
25 which the health system delivers care to that population.
26

27 THE COMMISSIONER: What should I understand by that, that
28 the important matters are what are the healthcare service
29 needs and can they be delivered safely, which might
30 involved different models of care and different
31 classifications of clinicians?
32

33 MS DOMINISH: Correct. And you are ensuring that in that
34 recipe of ingredients you've got, in your humans, that
35 you're making the best value of each of those individual
36 persons' skills, so that when you put it all together it is
37 effective and it is an enjoyable environment for the staff
38 to work in and also a good outcome for the patients.
39

40 MS CROSS: Can I just add that the other thing is,
41 I guess, that workforce pipeline. An assistant of nursing
42 will go on to become an enrolled nurse. The enrolled nurse
43 pipeline is a very healthy one to go on to become
44 a registered nurse as well. I think that's particularly
45 effective in our rural/regional areas as well, pertaining
46 to that "grow your own" focus as well.
47

1 MR MUSTON: Mr Whaites, we have broken the seal on this
2 topic so do you want to say something? I anticipate you
3 might have a subtly different view.
4

5 MR WHAITES: Where to start? I think the portrayal of
6 a nurse to patient ratio system as being rigid and
7 inflexible is, to be frank, ideologically driven. We have
8 a number of ratios approaches, that are dependent on the
9 type of service, the size of the service and the complexity
10 of the service. The ratios approach also envisages models
11 of care. It doesn't drive away from that. And where we do
12 have percentages of registered nurse to other
13 classifications, that is evidence based, research based.
14 It is not association ideology.
15

16 We have decades of evidence that shows that once you
17 get below an 80 per cent RN skill mix in an acute care
18 setting, your morbidity and mortality starts to increase.
19 We have evidence to show that when you have nurse to
20 patient ratios in place, actually, the patient outcomes are
21 better and because the patient outcomes are better it is
22 more cost efficient to the healthcare service.
23

24 The question of pipeline as it relates to the
25 utilisation of AINs, ENs and RNs we are very cognisant of.
26 It used to be that nursing was a way out of poverty for
27 people. You could work as an assistant in nursing whilst
28 you did your enrolled nurse training. There were no costs
29 associated with that. You went through TAFE, you had
30 hospital-based clinical practice and experience and then
31 you could go on to university, again, fee free, and become
32 a registered nurse, move from, you know, no employment to
33 secure long-term employment in the public sector.
34

35 We have a lot of enrolled nurses who now tell us that
36 the length of the courses, cost of the courses and the wage
37 differentiation from being an enrolled nurse level 5 to
38 being a first year registered nurse is not economically
39 viable for them.
40

41 We also see in the small regional towns where it could
42 be of most use, you will have someone who is an enrolled
43 nurse but there is no registered nurse position for them to
44 go into. So to give up their enrolled nurse position would
45 mean relocating their family at times that's not
46 appropriate.
47

1 I think there is an awful lot to say on this, but to
2 present ratios as rigid and inflexible and a barrier to
3 pipeline is not accurate.
4

5 MR MUSTON: Can I ask in relation to that, you said that
6 you have a number of ratios and approaches that are
7 dependent on the type of service. Where do they sit in
8 terms of - let's say we're dealing with a small rural MPS
9 that might have predominantly an aged care population with
10 a small emergency department on the side, where does one go
11 to to find the ratios that are applicable to that setting
12 as distinct from, say, the emergency department at a busy
13 city hospital like RPA?
14

15 MR WHAITES: For the level A, B and C facilities, we have
16 a one to four ratio - the skill mix varies depending on the
17 nature of the Cs. For the tiny hospitals that you are
18 proposing, we merely require that there be at least two
19 registered nurses on duty 24 hours, and we put that claim
20 to the government, the government has agreed to that,
21 because in a number of those facilities, after 4 o'clock,
22 5 o'clock, you would only have two people in the entire
23 hospital.
24

25 Both of those under the award ought to be a registered
26 nurse, but often it is a registered nurse and an enrolled
27 nurse or a registered nurse and an AIN, and when someone
28 presents to the ED, both of those staff members are
29 required to be in the ED at times depending on the incident
30 they are responding to, which leaves the rest of the
31 facility unstaffed. Now, we know that those EDs, they
32 don't take retrievals, the ambulances don't tend to go
33 there but the locals tend to turn up, and so they can and
34 do deal with category 1 episodes requiring both people to
35 be in the ED for quite some time.
36

37 So the only call that we have put in those facilities
38 is that there must be two registered nurses on duty
39 24 hours in order to allow for a third person to be in the
40 rest of the facility and for any category 1 or emergent
41 situations to be dealt with.
42

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

1 responsibility falling back to them. There's no on-call
2 systems. Very often people, other staff members, live
3 a distance away from the hospital, and so they will just
4 not accept that level of responsibility and risk to their
5 registration, so they don't hang around.
6

7 So having at least two RNs on duty 24/7 we see as
8 safer for the community and more able to attract people to
9 stay, because they can practice safely.
10

11 MR MUSTON: Could I ask you, Ms Cross, to perhaps respond
12 to two aspects of that. The first is the idea that ratios
13 might be inflexible in a way that prevents the
14 implementation of what the ministry perceives to be a safe
15 mix of nurse to patient ratio supplemented with enrolled
16 nurses, AINs and other health practitioners - what is it
17 about the existing system which creates the inflexibility,
18 if I have understood you correctly?
19

20 MS CROSS: I think it's moving into the proposed ratio
21 structure. So if we use AINs, an example of that is we
22 currently use our undergraduate students in AIN roles, and
23 certainly there is a model being piloted at Western Sydney
24 Local Health District, Nepean Blue Mountains and
25 South-Western.
26

27 They are fortunate because they do currently have some
28 lines in their staffing profiles that they can utilise for
29 the undergraduate AINs, but to actually expand that any
30 further would be challenged, because there would be
31 a limitation to the numbers of AINs that they're able to
32 put on, particularly to the acute wards and the like.
33

34 So that's probably a very practical example of a
35 challenge there around, I guess, any future thinking about
36 how we can grow that undergraduate AIN model so we can help
37 support that work-ready type example.
38

39 MR MUSTON: In terms of the proposition that ratios are
40 inflexible, is built into that an assumption that in some
41 circumstances, the existing or proposed ratios - and tell
42 me which - are not necessarily required from a patient
43 safety point of view?
44

45 MS CROSS: Sorry, I don't understand.
46

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

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

7
8 MS CROSS: I see. Well, my understanding - Mr Whaites
9 probably knows a little bit more - is that it is around the
10 cap on how many you can actually have per unit. In the
11 past you might have looked at what was happening in a
12 particular shift or whatever and you might say, "We can
13 actually accommodate one or two here, if we're unable to
14 get other staff", where there will be set ideas around
15 maybe you can only have one per ward, or I guess revisiting
16 the models as well, that would be part of the negotiation,
17 saying, "Well, we now think we can change that skill mix,
18 that nursing skill mix", which will require negotiation.
19 That's what normally would happen anyway.

20
21 MR MUSTON: I might need to unpack that. So from a ratios
22 point of view there is a number of registered nurses per
23 patient ratio which I think conceptually we can all
24 understand within a particular facility.

25
26 MS CROSS: Yes.

27
28 MR MUSTON: Are there other ratios built into this?

29
30 MS CROSS: Then there's the staffing - the ratio, I guess,
31 for RN to EN to AIN within that.

32
33 MR MUSTON: So there is a minimum number of registered
34 nurses per patient which is part of the ratio --

35
36 MS CROSS: Yes.

37
38 MR MUSTON: -- or per patient population.

39
40 MS CROSS: Yes.

41
42 MR MUSTON: Then there is a maximum number of assistants
43 in nursing per unit or per patient; is that correct?

44
45 MS CROSS: Yes, correct, yes.

46
47 MR MUSTON: Perhaps, Mr Whaites, you could explain that to

1 us.

2

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

11

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

23

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

28

29 MR WHAITES: Yes.

30

31 MR MUSTON: Would there be a problem, at least from your
32 point of view, Mr Whaites, with the idea that if you had
33 10 of them, you could employ eight registered nurses, one
34 enrolled nurse and one assistant in nursing, and perhaps
35 then add an extra assistant in nursing so the total
36 workforce is 11, but you have got more than your one
37 assistant in nursing? Would that be problematic or would
38 that not be problematic?

39

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

43

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

1 starts to speak against itself, in my mind, because what we
2 know is that hospital budgets will be set, they will be set
3 to employ against that level - they are now.
4

5 We already have managers that talk to us about the
6 fact that they've got people applying, registered nurses,
7 applying to work in smaller hospitals, but because there is
8 an EN budget line they're not allowed to employ that nurse,
9 that mightn't be a position of the ministry but it's
10 certainly what happens on the ground.
11

12 So to have multiple quarantined AIN positions on
13 roster lines in order to grow the registered nurse position
14 when the budget won't fit, you are not growing the
15 registered nurse because you are just creating more AIN
16 positions.
17

18 I think one of the other fundamental concerns for us
19 is that the more you dilute the skill mix, the greater the
20 workload on the registered nurses, because of the added
21 responsibility that they have to take.
22

23 When we look at, in particular, midwifery, the burnout
24 that is expressed by our members is partly because they are
25 working short but partly because of the additional loads
26 they have to take on with a junior or low-skill-mix
27 workforce. So it is not an automatic fix that having more
28 AINs in the system will grow us more RNs.
29

30 THE COMMISSIONER: Ms Dominish, you wanted to add
31 something?
32

33 MS DOMINISH: Yes, I just wanted to add something to this.
34 My expertise is more around models and scopes of practice
35 and looking at the services as a whole.
36

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

1
2 But within the nursing workforce itself - and if we
3 look at the pipeline - my understanding is, and correct me
4 if I'm wrong, that the ratios that are set for the RNs
5 don't include other RNs that may be available to support
6 junior workforce and/or students, such as clinical nurse
7 educators, clinical nurse consultants, nurse practitioners,
8 and that's within nursing, and understanding those
9 individuals do have specific roles and functions that they
10 undertake, but it's not just about the registered nurses
11 pure; there's a lot of other things that are going on
12 around that.

13
14 I think there is concern, you know, from the changes
15 that we're moving into where, if there's a maldistribution
16 issue and we can't recruit to those set ratios, and there's
17 potentially consequences for districts around the
18 agreements that have been reached from an industrial
19 perspective, then what do we do, because we still have to
20 keep the lights on and operate the services. Whilst there
21 might be an ideal situation to do that, that's not always
22 going to be possible, particularly in our rural and remote
23 environments and where we have challenges recruiting. So
24 that is just what I would like to add to the conversation.

25
26 MR MUSTON: Could I ask you, Professor Baird - we might
27 come back to the potential value of assistants in nursing
28 from a workforce pipeline point of view and the way in
29 which training pathways and workforce pathways might
30 overlap - do you have a view on the issue that we've been
31 discussing around ratios informed by your experience? And
32 if you don't, you are welcome to say that.

33
34 PROFESSOR BAIRD: Thank you. I would defer to the
35 expertise around the table, but certainly whatever
36 decisions we make should be around patient safety, employee
37 safety, so yes, I agree ratios are really important but we
38 have to deliver a service. But I'm not working in that
39 particular field, so I'm going to defer to the other
40 experts around the table.

41
42 MR MUSTON: Can I throw this question out to all of you
43 and any of you can answer. Is there a need to include
44 those sorts of ratios as part of an industrial arrangement
45 as opposed to the decisions around the operation of
46 individual facilities and, if so, why?
47

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

8
9 We know that compliance with existing award provisions
10 is not always enforced and we have countless stories of our
11 members referring up dangerous staffing levels to their
12 managers and being given very short-change answers around,
13 "Well, that's all there is, you'll just have to cope." We
14 don't believe that that is the standard that the community
15 expects and it's not a standard that keeps our members safe
16 professionally.

17
18 Often when there are adverse events on the wards, it
19 is our members that end up in front of the coroners, it is
20 our members that end up being questioned and our members
21 that face possible restrictions on their registration,
22 which can be a product of short staffing and not being able
23 to get things resolved.

24
25 So from our perspective, it is absolutely crucial that
26 minimum staffing levels be in an award and that they be
27 enforceable, so that for both our members, but for the
28 broader community, there is accountability and transparency
29 in provision of best practice. Again, I go back to the
30 literature that says that ratios improve morbidity and
31 mortality and are more cost effective.

32
33 MR MUSTON: What about the proposition that Ms Dominish
34 raised, that in some facilities it's not practically
35 possible to actually secure and retain workforce
36 consistently within a particular fixed ratio? I will come
37 the ministry about this in a minute, but, Mr Whaites,
38 what's your response to that or how should that situation
39 be addressed if and when it arises?

40
41 MR WHAITES: There is evidence, a number of reports again,
42 if you look at midwifery, there was the recent FUSCHIA
43 report out of La Trobe University that spoke about the
44 reasons why people are leaving the industry, members are
45 leaving the industry, nurses and midwives leaving the
46 industry or reducing their hours, and it's because of -
47 well, in the FUCHSIA report, it was workloads, the level of

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

7
8 Yes, there are other classifications of nurses. We
9 note that the proportion of CNEs is dropping rather than
10 increasing. And of course there are other classifications
11 of workers that are in hospitals and we warmly embrace
12 there being more of those as well. Our wicket is nursing
13 and midwifery and that's what we seek to ensure we have
14 minimum staffing levels for.

15
16 MR MUSTON: Going back to my question, though, do you have
17 a solution to a situation where it proves impossible to
18 secure sufficient nurses to meet the existing - or do you
19 have a solution to a scenario where insufficient nurses to
20 meet a particular ratio could be secured in, say, a small
21 rural facility? How does one deal with that if it is part
22 of an industrial award?

23
24 MR WHAITES: Part of the industrial agreement, although it
25 is not written yet the agreement is there - where there is
26 ongoing demonstrated difficulty in recruiting to those
27 vacancies, we, of course, will go into discussions with the
28 ministry about alternate workforces until such time as
29 recruitment can be improved. So it's certainly not
30 a barrier and you certainly won't see any wards or units or
31 hospitals shut down.

32
33 THE COMMISSIONER: So the way I should understand your
34 answer to Mr Muston's question, the first part of your
35 answer I think was there is a whole lot of things that
36 could be improved, and I'm not suggesting this is the only
37 one but I can still hear "pay" in my head, and that might
38 be a means of improving attraction and retention, but if
39 the world was perfect and there was still a recruitment
40 problem or a problem with staffing, then you go into
41 negotiations?

42
43 MR WHAITES: Yes. So the proposed award clauses, the
44 framework that we have agreement around is where there is
45 a demonstrated inability to recruit to those numbers, then
46 we will agree an alternate ratio, we'll agree alternate
47 models.

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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

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

5
6 MR WHAITES: No impact on the MPSs at this stage. Again
7 our claim is only for a minimum of three on every shift,
8 two of whom should be registered nurses. We are yet to
9 agree what the ratio will be for the level 2 emergency
10 departments in the community hospitals as opposed to the
11 MPSs.

12
13 MR MUSTON: Ms Cross or Ms Dominish, did you want to
14 contribute to or respond to that discussion around ratios
15 in particular?

16
17 MS CROSS: I just want to respond, I suppose, to some of
18 the statements before. I think everybody in the health
19 system endeavours every day to make sure that we are
20 providing safe, quality care and we get the right skill mix
21 and we're able to deliver that with the right work mix as
22 well. Sometimes there are shortages and we do need to look
23 at alternate ways of doing that. I guess, I just wanted to
24 make that clear after some of the statements from
25 Mr Whaites.

26
27 MR MUSTON: Can I ask you a question about that: is it
28 the case that there are different views about what does
29 amount to safe care in terms of ratios and workforce mix?
30 We've heard from Mr Whaites that there is research that
31 supports the proposition that the ratios being advanced
32 provide safe care, provide long-term savings within the
33 health budget and the like, but is that contested ground,
34 the question around what the ideal mix is or what a safe
35 mix is?

36
37 MS CROSS: Look, it's a really complex area and there is
38 research for everything that you want to have a look at.
39 I think, too, the clinical settings, the mix of patients
40 that we have, the care needs that are required are so
41 diverse as well, and you know, we really do need to also
42 include there the nursing expertise and decision-making
43 that's made around how we deliver that care. That means
44 how we come together as a nursing team, along with our
45 other healthcare professionals as well, escalation pathways
46 are there, if there are concerns around what the staffing
47 levels might look like or the acuity of the patients that

1 we're caring for as well. So it's relatively nuanced and
2 really complex at times, and it moves. I think this is
3 about the flexibility as well.
4

5 MR MUSTON: Can I ask, Mr Whaites, do you agree that it's
6 dynamic and varies depending on the particular setting -
7 that is to say, what amounts to safe care in terms of the
8 workforce mix?
9

10 MR WHAITES: It does, which is why we don't have one ratio
11 for every setting. Again, there is decades of research to
12 show the benefits of nurse to patient ratios, the minimum
13 of 80 per cent registered nurses for acute medical surgical
14 wards, which is where we're seeking to have that applied.
15 The variation occurs, absolutely. There is nothing
16 preventing the employer from providing a greater skill mix
17 or more staff. In fact, we know when patients require
18 specialty, so one nurse per patient for a period of time
19 due to a number of reasons, that hospitals will provide
20 that additional staffing level. And we agree, it should be
21 flexible, but the lived experience of our members is that
22 the flexibility tends to run one way and the number of
23 shifts that they work short or with low and what we would
24 say is an inadequate skill mix is too common.
25

26 MR MUSTON: Do you accept that there is variation in views
27 expressed in research about what amounts to a safe skill
28 mix? You have referred a number of times to decades of
29 research that point to, say, your 80 per cent registered
30 nursing workforce being ideal. Do you accept that there
31 is, as I think Ms Cross has suggested, research that could
32 be called upon to say different ratios or different mixes
33 of RN/EN/AIN medical workforce can provide safe outcomes?
34

35 MR WHAITES: Yes, there are articles that will call into
36 question the evidence of other pieces of research. I'm not
37 aware that there has been a competent review of
38 meta-analysis of all of the research put together. I've
39 read some pieces that have attempted to do that and they
40 say that, on the balance, nurse to patient ratios are cost
41 effective and do have benefit for the patient outcomes.
42

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

1 recent evidence suggests we're on the right path.

2

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

9

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

20

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

29

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

35

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

38

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

43

44 MR GRIFFITHS: That's right.

45

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

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

5
6 MR GRIFFITHS: Yes, and look, data isn't the only source
7 of that information. As a networked health service, we
8 maintain, pretty close contacts with the directors of
9 nursing in those organisations and the directors of people
10 and culture. So we have a fair understanding around our
11 areas of challenge.

12
13 MR MUSTON: How does that information feed into the work
14 that your group does - that is, the relationship with the
15 directors of nursing, and the like the on-the-ground
16 experience of workforce shortages?

17
18 MR GRIFFITHS: We get a very clear message from them
19 around where their pain points are. If I think about
20 a recent initiative, our organisation entered into
21 a statewide contract with nursing agencies because we heard
22 of pain points around the availability of price in terms of
23 nursing agencies. That was playing out differently in
24 different local health districts. Some prices were fairly
25 elevated in local health districts and others weren't as
26 impacted.

27
28 So the conversation with the directors of nursing and
29 the directors of people and culture related to the fact
30 that they can't - that there is a different experience
31 across the state, and that budgets are much more universal
32 in terms of the way that we formulate a budget for
33 a district. So we negotiated a statewide contract which is
34 bringing, and will continue to bring, prices down in terms
35 of the cost of agency workforce.

36
37 MR MUSTON: Ms Dominish, I think you were gesturing that
38 you might have wanted to add something there.

39
40 MS DOMINISH: I would add a couple of things to Richard's
41 comments.

42
43 In the previous hearings I gave evidence about the
44 workforce modelling that we undertake and, as Richard said,
45 we gather information on a regular basis from a variety of
46 sources, and the district directors of nursing and
47 midwifery are one of those. However, the work of the

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

14
15 I was going to make another point and I've lost my
16 train of thought I think. Oh, that was the other thing.
17 In terms of responsiveness to where we can see there's
18 a significant issue, the minister just announced an
19 initiative to bump up the incentive bonus for midwives for
20 areas of MM3 to MM7, so that's an immediate response where
21 we've seen there's an urgent need to do something while
22 we're trying to work on the pipeline issues, which is going
23 to take some time.

24
25 THE COMMISSIONER: Is this the \$20,000?

26
27 MS DOMINISH: Correct. It's been bumped up from 10 to 20;
28 is that right?

29
30 MR GRIFFITHS: Yes, it's 20,000 now for all midwives in
31 MM3 to MM7 locations. So we haven't scaled it. We've used
32 it as a sign-up bonus.

33
34 MR MUSTON: Just to try to understand it a bit better, the
35 data that you have currently, that is before you finish
36 this 18-month program, does it currently tell you where
37 there are immediate needs for nursing and midwifery
38 workforce of particular types, enrolled nurse, registered
39 nurse and midwives? That is to say, would you know if
40 there was a particular need in a particular facility in,
41 say, Brewarrina, hypothetically?

42
43 MS DOMINISH: That would usually come to us, and I will
44 defer to Jacqui and Richard, through that relationship and
45 the qualitative discussions we're having around the nuances
46 of what's going on in specific sites. I don't know if we
47 monitor it down to the facility level currently but I might

1 let Richard and Jacqui speak to that.

2

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

7

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

19

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

23

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

32

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

42

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

45

46 MS CROSS: No.

47

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

9
10 Metro is a different story. That is really more the
11 local health district that has more of a handle on its
12 supply challenges.

13
14 I don't want to speak in generalisations, but Sydney
15 is relatively well supplied in terms of the nursing
16 workforce. Our challenge really is those outlying areas.
17 So even the outlying areas of Sydney are relatively
18 challenged. So anything sort of MM2 onwards are the areas
19 where we see more recruitment challenge. That's not
20 necessarily to say that there aren't some specialties that
21 are short, and we definitely have some challenges in terms
22 of supply for some of those nursing specialties.

23
24 THE COMMISSIONER: When you say "Sydney is relatively well
25 supplied in terms of nursing workforce", does that include
26 midwives?

27
28 MR GRIFFITHS: Not midwives. Midwives is universally
29 problematic.

30
31 THE COMMISSIONER: Can I just ask you something about that
32 so that I understand it: do you have your statement?

33
34 MR GRIFFITHS: I do.

35
36 THE COMMISSIONER: The recent one, paragraph 31, just so
37 I understand all that you're conveying here. So in 30 you
38 tell me that the numbers of midwives graduating and
39 projected to graduate are falling behind demand. Then you
40 talk about Australia and internationally and the work
41 currently being undertaken, and then you tell me that in
42 New South Wales the midwifery shortage is as a result of an
43 ageing workforce, and I can understand that, there are
44 a lot of people heading towards retirement or retiring;
45 reduction in worked hours - why is there a reduction in
46 worked hours?

1 MR GRIFFITHS: There is a propensity for people to both
2 work part time, as opposed to choosing to work full time --
3
4 THE COMMISSIONER: This is the choice of the midwife,
5 then, to work less hours?
6
7 MR GRIFFITHS: Yes. By choice, correct
8
9 MS CROSS: Richard, there's maternity leave as well for
10 the midwives, that's part of that - returning to work part
11 time. It's a younger workforce and it's predominantly
12 female.
13
14 THE COMMISSIONER: Then there's "accessibility to training
15 programs in regional and rural areas". I take that to mean
16 a lack of accessibility, is it?
17
18 MR GRIFFITHS: Yes, it is a challenge, yes.
19
20 THE COMMISSIONER: And "the maldistribution of employees
21 across metro and regional areas", then "increased
22 complexity of maternity care needs". What should
23 I understand that to mean?
24
25 MR GRIFFITHS: There is a desire for more experienced
26 midwives in maternity units.
27
28 THE COMMISSIONER: From the patients?
29
30 MR GRIFFITHS: No, from hospitals.
31
32 THE COMMISSIONER: From the hospitals. Okay.
33
34 MR GRIFFITHS: Yes.
35
36 MS DOMINISH: Could I just add something to that around
37 the complexity?
38
39 THE COMMISSIONER: Yes, of course.
40
41 MS DOMINISH: Zooming out to look at the context in the
42 state, so particularly in our rural and remote areas we
43 have difficulties with GPs and GP obstetricians, and so if
44 you're looking at maternity services and the role of
45 midwives, there's pressure on junior doctors and on GPs to
46 provide those services particularly in areas where there
47 are not many people around, as in clinicians and then --

1
2 MR MUSTON: Pausing there, when you say you have
3 difficulties with GPs and GP obstetricians, I assume you
4 mean difficulty getting them?

5
6 MS DOMINISH: Yes, they are in decline, and the
7 GP obstetricians --

8
9 THE COMMISSIONER: This leads to the importance of
10 midwifery models of care, maternity services?

11
12 MS DOMINISH: Correct. Because whilst we have incredible
13 midwives that provide leadership in those midwifery group
14 practice models, there are always going to be circumstances
15 where you have to have access to a doctor, to an
16 obstetrician, and the knock-on effects we're seeing in
17 general practice obstetrics, junior doctors wanting to work
18 in rural areas to become obstetricians or to become rural
19 generalists, when you put that whole picture together,
20 trying encourage people to be midwives and midwives in
21 rural areas, it adds another layer of stress and complexity
22 and a challenge for districts to keep those services open.

23
24 MR MUSTON: I will come to you in a moment, Ms Cross.
25 I think Mr Whaites has been patiently waiting.

26
27 MR WHAITES: Just a couple of things very quickly. We
28 note that the ministry has been renegotiating the agency
29 fees. Our concern is, in the absence of another workforce
30 available, it's merely going to mean that people won't take
31 up those agency shifts and relocate. We appreciate the
32 push and pull that that's creating but you can't just take
33 away that workforce without having a plan, and we say that
34 plan is better wages to attract people there in the first
35 place.

36
37 When you look at the request for more senior midwives,
38 absolutely, our data - sorry, it is the Ministry of
39 Health's data, we GIPAA the ministry on a regular basis -
40 what we see is since 2016 to now, there's been over a
41 10 per cent, I think it is getting closer to a 12 per cent
42 reduction in the number of senior midwives that are working
43 in the system. So that's not about people retiring,
44 because you would imagine that people age, they move up the
45 scales automatically, it means that they are not retaining
46 the midwives in order to become senior midwives. There's
47 a problem there.

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

11
12 I think also we've got data there --

13
14 THE COMMISSIONER: Sorry, can I just ask you to pause
15 there. I understand pay.

16
17 MR WHAITES: Yes.

18
19 THE COMMISSIONER: Workload means specifically what, when
20 you're talking about that as a problem?

21
22 MR WHAITES: So one example of that is the number of
23 midwives on a postnatal ward, particularly with the
24 increasing intervention rate, increasing numbers of
25 caesarean sections, when you have inadequate numbers of
26 midwives on a shift then, you know, that's an unreasonable
27 workload. So that's an example of that.

28
29 THE COMMISSIONER: And lack of respect I understand
30 generally, but where is the lack of respect coming from?

31
32 MR WHAITES: Our members talk about a general lack of
33 respect either from within their workplace or how they are
34 perceived within the system. So if I go large scale for
35 you and we talk about solutions, absolutely agree, the call
36 for midwifery-led models of care and greater utilisation of
37 that we strongly support. It is an easy and identifiable
38 solution. All of the evidence shows that such models of
39 care provide better outcomes, the women rate them more
40 effectively and they are - unfortunately, our midwives are
41 not paid the same rate as an obstetrician, so they are
42 therefore more affordable. There are barriers to those
43 being established and that's around the autonomy of those
44 midwifery-led models of care, but we think that there is
45 a great opportunity for some pilot models to be run.

46
47 THE COMMISSIONER: Let me ask you a different question.

1 Is the lack of respect that you are talking about more
2 isolated examples than systemic or do you think it's
3 systemic?
4

5 MR WHAITES: I think on one level it's systemic. The
6 barriers to having midwifery-led models of care and the
7 perceptions of others that midwives can't possibly take
8 total case responsibility --
9

10 THE COMMISSIONER: It's lack of respect for the skills, is
11 it?
12

13 MR WHAITES: Yes, and I think there is an increasing - so
14 midwifery-led models of care are typically applied for
15 low-risk populations, but when you look at what will put
16 a woman into a high-risk category, midwives are still more
17 than able to look after that cohort of women as well. So
18 some movement around the definitions of which high-risk
19 women midwives can look after, what referral processes we
20 have in place to make sure that it is safe and what urgent
21 transport services we have available also - there's a lot
22 to look at there but there is some great potential.
23

24 THE COMMISSIONER: All right. Did anyone want to respond
25 to anything Mr Whaites just said in those last answers?
26 All of you should feel free to just chip in when you need
27 to.
28

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

1 supporting the midwives to actually engage and to advocate
2 for those models of care as well. So we're giving them
3 skills to do that.
4

5 Another piece of work that we've just finalised is we
6 have been looking at actually how we support midwives in
7 their practice. So we've developed a sort of central
8 portal, which we're calling the "Midwifery pathways of
9 practice", to actually access that skill. Again that's
10 twofold: that's actually to tell the system that we
11 believe our midwives can be doing the sort of clinical
12 procedures and the like as well, and supporting them to do
13 it. So there is a whole suite of work happening.
14

15 I guess on to the point of a more junior workforce, we
16 are investing heavily in the student midwifery workforce
17 because that's our way of growing midwives as well, so how
18 we support the midwives to gain skills.
19

20 THE COMMISSIONER: Can I ask a follow-up on that to
21 Mr Griffiths. Going back to your statement, in 33 you
22 said, in relation to the Bachelor of Midwifery, "our
23 workforce modelling has identified an undersupply". What
24 should I understand to be the extent of the undersupply?
25

26 MR GRIFFITHS: Well, I don't have that in front of me,
27 Commissioner, but --
28

29 THE COMMISSIONER: You can take it on notice, but just
30 a general sense? How big is it? How big is the problem?
31

32 MR GRIFFITHS: I will take it on notice. Look, in terms
33 of the size of the problem, essentially what that means is
34 our university graduates aren't keeping up with the demand
35 in service.
36

37 But the other thing I was going to add, and Ms Cross
38 sort of alluded to it --
39

40 THE COMMISSIONER: That doesn't have to amount to much
41 to become a significant problem.
42

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

1 two pipelines.

2
3 The other states are relying on the bachelor program.
4 Our MidStart program is really giving us an alternate
5 supply. In fact, I have put in my statement at the moment
6 it is a stronger supply than the bachelor program. It is
7 a program that provides us with an experienced registered
8 nurse, so we don't have that level of immediate
9 career-starter status, when you get someone straight out of
10 university. So while it is a challenge, some of the other
11 states are a little envious that we have continued with our
12 MidStart, and that is helping us. I think the problem
13 would have been more significant had we done what the other
14 states have done and closed off that as the training
15 pipeline.

16
17 THE COMMISSIONER: Should I take from that also that where
18 you say in 31 there is a recognised shortage of midwives
19 across Australia, the undersupply in New South Wales is in
20 percentage terms not really significantly different to any
21 other state?

22
23 MR GRIFFITHS: It is not. Yes.

24
25 MS CROSS: Can I just add, too, just on the point around
26 being mid pathway, again, we're doing a big body of work to
27 actually increase the number of student midwives coming
28 through that pathway. So we have got data to show that
29 that hasn't met what we've required. So we've actually got
30 quite close with the districts to increase those numbers --
31

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

34
35 MR WHAITES: MidStart preceded the bachelor of midwifery.
36 It was how I became a midwife, a registered nurse first and
37 then a midwife. Can I just comment --

38
39 THE COMMISSIONER: Of course.

40
41 MR WHAITES: The data we've seen and is within the rapid
42 business case, which was also a submission to this Inquiry,
43 shows that New South Wales consistently has a higher number
44 of midwives in New South Wales who are not working in
45 midwifery.

46
47 THE COMMISSIONER: The rapid business case, is that to do

1 with the award?

2

3 MR WHAITES: That's the Deloitte - yes.

4

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

6

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

11

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

17

18 THE COMMISSIONER: Of this month?

19

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

22

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

26

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

29

30 THE COMMISSIONER: It is only a few days.

31

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

40

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

44

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

46

47 THE COMMISSIONER: Of course, yes.

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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

1 me about the contributing factors. One is the availability
2 of clinical placements - and let's just worry about LHDs.
3 So a lack of clinical placements - why?
4

5 MR GRIFFITHS: There's a couple of reasons. One is that
6 to get the number of graduates there's a bit of a catch-up
7 period for the bachelor program, which means that we
8 probably need to have more students in place than what
9 we've historically had, and there's work that we need to do
10 from the ministry with the health system around the burden
11 that students present - well, the opportunities those
12 students present to the health system, but there is --
13

14 THE COMMISSIONER: Is it a funding thing?
15

16 MR GRIFFITHS: No, it's a capacity issue.
17

18 THE COMMISSIONER: Right, I see.
19

20 MR GRIFFITHS: It relates to the supervision of those
21 students. But there are things that we can do there to
22 work through the way that we manage student placements with
23 the health system, plus also with our university partners,
24 and I can see Ms Cross is keen to contribute.
25

26 MS CROSS: I guess that's the work I was just talking
27 about before. One of the sort of fundamental pieces that
28 we've been doing is the mentoring piece. That was
29 supporting our current midwives to support the student
30 midwives and the future midwives, but also, I guess,
31 working with the managers of those services as well, so
32 they can actually understand what - well, not understand
33 but actually further understand what the throughput is, the
34 complexity that they've got, the current staffing levels
35 that they have, what would occur if they continue with the
36 student numbers that they currently have and what their
37 uplift needs to be to actually support them to do that.
38 That's just assisting them to plan, thinking forward around
39 how they're going to get a good workforce into the future.
40

41 THE COMMISSIONER: Just finally on 33, you say that the
42 alternative postgraduate pathway - and we've discussed
43 MidStart - has been the stronger pathway. Is there
44 anything you want to expand upon about why you think it has
45 been the stronger pathway or what the evidence reveals?
46

47 MR GRIFFITHS: In terms of the strength of the pathway

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

4
5 THE COMMISSIONER: It is just a numbers thing?

6
7 MR GRIFFITHS: Yes - well, yes, but there is also the
8 value of having an experienced registered nurse working in
9 that pathway.

10
11 But, Commissioner, I know that I was focusing on LHD
12 capacity, but, you know, if you were looking at broader
13 solutions to this program, there really is an opportunity
14 for the system to come together with private hospitals
15 around capacity, because there is a healthy maternity
16 private market, and if we're really serious about
17 increasing the number of graduates, then we both need to be
18 at the table looking at capacity and supporting those
19 students.

20
21 It's beneficial for students to get experience across
22 both, because you come into the public system --

23
24 THE COMMISSIONER: And that doesn't happen?

25
26 MR GRIFFITHS: It's siloed. Yes.

27
28 THE COMMISSIONER: All right.

29
30 MR MUSTON: We might explore that after morning tea.

31
32 THE COMMISSIONER: All right. We'll take a break until
33 11.50. We'll adjourn until then. Thank you.

34
35 **SHORT ADJOURNMENT**

36
37 THE COMMISSIONER: When you are ready.

38
39 MR MUSTON: I will just give everyone a moment to get
40 settled.

41
42 THE COMMISSIONER: Sure.

43
44 MR MUSTON: Professor Baird, I was going to turn to you
45 now to ask you some questions about that workforce
46 pipeline, and perhaps if we start with midwifery, given
47 it's the topic that we've been addressing. What does that

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

3
4 PROFESSOR BAIRD: Thank you for that question. I would
5 just like to say I'm actually one of the key researchers
6 involved with the "Midwifery Futures" project, and that
7 actually came from the Burnett Institute with UTS. I will
8 seek permission to see if I can share that report with the
9 Commission. It is due to be released on 23 October.

10
11 THE COMMISSIONER: Thank you.

12
13 PROFESSOR BAIRD: I think it would be really helpful in
14 terms of modelling of each state, and it clearly shows the
15 number of predicted future midwives that New South Wales
16 may need to account for the shortages. So I just wanted to
17 say that.

18
19 Clearly we have a shortage of midwives and I can only
20 speak from the perspective of a higher education institute
21 like UTS, and also around - we do run the two programs, as
22 Richard has said, the MidStart graduate diploma of
23 midwifery and also the bachelor of midwifery program.

24
25 All I know with the bachelor of midwifery program, it
26 is so highly subscribed to, our ATAR sits at 97 for entry
27 into our program. We do have other pathways that UTS
28 supports for our Aboriginal and Torres Strait Islanders and
29 students from low socioeconomic backgrounds, so we can have
30 a pathway to support them, because clearly what the data
31 also shows from the "Midwifery Futures" report is that we
32 don't have enough Aboriginal and Torres Strait Islander
33 midwives coming into the profession.

34
35 So if I can give you an example, we had over 700
36 applicants for 80 bachelor of midwifery places last year.
37 So the course is very popular, but we are constrained by
38 how many placements we can offer the students that we have.

39
40 I do want to acknowledge the ministry and Jacqui
41 Cross. Particularly, since I moved into the role, we've
42 increased the midwifery placements by 20 per cent. If
43 there's opportunity to expand them to more, we could
44 certainly do that, but not without the clinical placements
45 to support the students.

46
47 MR MUSTON: So what are the limiting factors? You said

1 you had a huge number of applicants for a relatively small
2 number of positions. In the context of a section of the
3 workforce which sounds like it's in desperate need and an
4 area, a workforce area where a graduate could presumably
5 walk into a job within the public health system, what is it
6 that constrains the number of places that you are able to
7 offer students who wish to study in this area? You have
8 touched on clinical placements. Is there anything else?
9

10 PROFESSOR BAIRD: With the MidStart program, we don't have
11 to source those clinical places. I'm very grateful to the
12 ministry. The ministry actually sources those places for
13 us. So we have to find placements for the bachelor of
14 midwifery students, and that is very much relationship
15 based. We have to source those placements ourselves, and
16 we've built up very good relationships with many of our
17 local health districts and our nursing and midwifery
18 directors. But we have several universities that are also
19 looking for clinical places for their students, too. So
20 those relationships are integral to securing our program.
21 So I would say it is very much relationship-based,
22 university with the local health district, the nursing and
23 the midwifery director.
24

25 I mean, we've been fortunate, we've been able to
26 increase the places with the support of the ministry, but
27 sometimes it feels that we could do a little bit more in
28 terms of sourcing some more clinical placements around
29 looking at how our students are supported in the clinical
30 placement, because obviously we wouldn't put students into
31 a clinical area if we didn't feel they were being well
32 supported.
33

34 MR MUSTON: So is it the availability of clinical
35 placements which is the key cap on your ability to train
36 more midwives through your institution, or are there other
37 limiting factors that come into play?
38

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

1 talk to those students it's not because they don't feel
2 supported in clinical environments, it's not because they
3 are not enjoying the course, it is sometimes related to
4 just the cost of living that I think everybody is
5 experiencing at the moment.
6

7 If we could even get free travel, free parking - just
8 small changes that perhaps we could look at, but those
9 decisions don't rest with us as an education institute, but
10 certainly those are things that perhaps we could think
11 about in the future.
12

13 MR MUSTON: In terms of the impact of the clinical
14 placement on career pathway, do you, viewing it from the
15 perspective of an educator, sort of at entry point, do you
16 have any observations that you have been able to make as to
17 the extent to which placements can impact on the way that
18 people's career progresses at least in the early years?
19 That is to say, do people tend to work where they end up
20 placed?
21

22 PROFESSOR BAIRD: Most do, because what we try to do is
23 give students a home base so they feel a sense of
24 belonging, and certainly that is what we've been doing with
25 our assistant in nursing program, with three of the local
26 health districts across Sydney. We're able to offer our
27 nursing students and some of our midwifery students an
28 assistant in nursing placement, and that means that that
29 student nurse or student midwife will, for two years, do
30 all their clinical placements in that local health
31 district, similar to what Jacqui was talking about earlier.
32

33 They get a sense of belonging, they get paid, working
34 in the field that they're going to move into when they
35 graduate, and what we've been able to agree with that local
36 health district is that at the end of the two years they
37 will automatically be offered a graduate position into that
38 local health district. So that sense of belonging, that
39 home hospital, I think, supports student nurses and
40 midwives to feel already part of that workforce. So far,
41 with one local health district, this is our second year of
42 running that program and we're doing an evaluation of that
43 and it's been very positive.
44

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

1 or a range of facilities?

2

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

10

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

17

18 PROFESSOR BAIRD: That's right.

19

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

21

22 MR MUSTON: Please do.

23

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

32

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

42

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

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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

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

13
14 MR MUSTON: From the perspective of an educational
15 institution vying for spots, Professor Baird, do you have
16 a view on how that system works and whether it could be
17 improved or adjusted by perhaps centralising the process a
18 little bit more and dealing with it in a slightly more
19 coordinated way than the existing arrangement between
20 institutions and local health districts?

21
22 PROFESSOR BAIRD: It is really complicated. If I look at
23 UTS, we have over 12,000 students, over 3,000 different
24 sites that we send students to. It's a logistical jigsaw
25 puzzle that we employ a lot of people to help us with. So
26 I think when you look at that across every university,
27 across the whole of New South Wales, it would be an
28 absolute - I wouldn't envy anyone having to do that.

29
30 I think there is probably scope to look to see if
31 there are different ways of doing that, but I'm not
32 across - I don't have the expertise that the ministry has
33 to think about what that would look like on a much larger
34 scale. It would certainly take away the need for that
35 relationship-based relationship, but it's how you would do
36 that fairly, as well, and that every university was treated
37 fairly, so I think it would be quite a logistical nightmare
38 but that's not to say it isn't something that could be
39 looked at, and maybe that would allow for the predicting
40 model of how many nurses do we need in five years' time,
41 how many midwives do we need in five years' time?

42
43 I can only talk from my experience in the UK where
44 that was very much done at the health district point of
45 view, but that was much smaller than what we're talking
46 about here. And all the other health professions that it
47 would involve around bringing into a hospital, student

1 paramedics, student physios - it's just huge.

2

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

12

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

21

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

35

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

44

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

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

8
9 But as Richard said, it really is about that
10 experience and also how do we support our staff on the
11 ground to support the students as well. For us in nursing,
12 it's on the back of the work that we've done with
13 midwifery, so really exploring with our nurses on the
14 floor, I guess, their capability, their confidence in being
15 able to support student nurses as well.

16
17 What we found in midwifery was there was a willingness
18 to support the students but they didn't feel that they had
19 the skills or the ability to do that, and as I said before,
20 that's why we've developed the mentoring program.

21
22 Midwifery is a nice little tight workforce and we're
23 able to get on the ground and work with them. My
24 experience has been that sometimes we have these programs,
25 mentoring programs, preceptorship programs, whatever we
26 like to call them, we roll them out and they have very
27 mixed success. That real success happens when we're able
28 to work on the ground with the staff, and again I keep
29 coming back to midwifery. We've had five years where we've
30 been able to do that and it is paying dividends now. So it
31 is complicated work. It does require, I think, close
32 support of the workforce on the ground.

33
34 MR MUSTON: But a system that allocates placements to
35 different institutions based on individual relationships
36 between LHDs and institutions and the particular deal, for
37 want of a better word, that an institution can bring to an
38 LHD in terms of accommodating students for placements in
39 and of itself has the capacity to produce some inequality,
40 at least between institutions, doesn't it?

41
42 MS CROSS: I think when I think about the relationship, to
43 me, it's actually more about the other pieces that fall out
44 of that, so supporting research, the co-joint appointments,
45 if there are some challenges in some particular areas, then
46 they can work that through and pick up the phone. I know
47 Kathleen and I have had one of those conversations.

1
2 So that is really critical as well, so where are the
3 touch points in that as well? But coming back to your
4 point about managing clinical placements, that was the
5 premise of ClinConnect as well, about building in some
6 equity that relationships come through the individual
7 agreements, but I think the actual sort of coordination
8 probably happens a bit more distant than that.

9
10 MR GRIFFITHS: I've got to say, though, I don't know that
11 the inequity in terms of the arrangements is felt at the
12 student level. I think that's more the organisations, and
13 having looked at the different agreements in place, they
14 sort of net out to be much the same, because there is give
15 and take on both sides that just ensures that we are able
16 to provide that student experience. So yes, there is some
17 variation at times in terms of price; if we're providing
18 the supervision there are some variations in terms of
19 price.

20
21 I sort of argued a couple of years ago that we sort of
22 operate in a bit of a free market economy really and
23 they've been able to strike that price through arrangements
24 based on what they can provide and what they can't provide.
25 I know that that does frustrate universities at times and
26 that might be something that we can look at. But the
27 student shouldn't feel the inequity.

28
29 I think the issue at the moment is things that are
30 outside our control that would provide a better student
31 experience, as Professor Baird has indicated, things like
32 the student poverty issue that is being raised in different
33 jurisdictions. That prevents good placement in hospitals
34 where we can provide a very good experience for that person
35 but we can't attract because they're too remote, for
36 example. So some of those things would be of benefit to us
37 in terms of improving the overall student experience but we
38 don't have those levers to pull.

39
40 MR MUSTON: Is there not scope, though, if the process
41 were more centralised and assessments were able to be made,
42 economic assessments were able to be made, say, of the
43 long-term benefit of placing a cohort of students in a very
44 difficult to fill position in, to use my hypothetical,
45 Brewarrina again, just because it is the one we keep
46 picking on, but that whilst there may be a cost, even to
47 the ministry, of providing a scholarship or funding

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

8
9 MR GRIFFITHS: Yes. I'm just thinking through that
10 Brewarrina example.

11
12 MR MUSTON: It might be a perfectly well staffed facility,
13 but --

14
15 MR GRIFFITHS: I know it's a hypothetical but the
16 challenge there is, obviously, whether there's activity and
17 supervision that would provide the experience. That's
18 where we would be relying - in those very hard to fill
19 areas where we're already struggling to attract
20 a workforce, we're probably not going to be able to provide
21 the supervision that would be required. So we would be
22 relying on the university to provide that supervision and
23 paying for it, and they are probably in the same position,
24 where they probably can't provide that supervision at that
25 location as well.

26
27 So I'd love to be able to place students in some of
28 those facilities, but there are so many things at the
29 moment that prevent us from doing it.

30
31 THE COMMISSIONER: That was a really remote example.

32
33 MR MUSTON: It was. Ms Dominish?

34
35 MS DOMINISH: Just, I suppose, looking at all the parts
36 connecting together - I can understand the concept of
37 saying, "Let's centralise it" and then we just send people
38 where we need to go, and I think the complexity has been
39 highlighted that that can't be done in a vacuum where the
40 qualitative information about what's going on across the
41 state and where placement capacity is which may change
42 from, you know, month to month or year to year, depending
43 on what's going on with workforces. But in terms of trying
44 to be solution focused, because I've had multiple
45 conversations about this over the years, and reflecting on
46 my experience having worked as an exec director in a
47 district, allied health, is, is there an opportunity for

1 us, as you've suggested, to possibly tighten up or
2 strengthen the governance at a state level and the
3 formalised relationship between health and education
4 providers?
5

6 What that looks like I don't know, because currently
7 we do that through the deans forums for medical nursing and
8 allied health, so we have dialogue and discussions and the
9 things like that. But currently at the state level,
10 I think the governance predominantly sits on the health
11 side of the fence and there's not that sort of partnership
12 formally with education providers, but acknowledging that
13 we aren't the only sector that is placing students.
14

15 Secondly, the policy that we've currently got around
16 student placements is quite focused on the
17 operationalisation of the student placement agreement, so
18 kind of once those discussions and bargaining has happened
19 between districts and education providers, then what are
20 the sorts of rules and terms and conditions around how that
21 can be done, although, as you have pointed out, deals are
22 done which we don't have any visibility over and they're
23 put as annexures to the student placement agreement and
24 they could be different from that hospital and that one
25 down the road.
26

27 So we don't have visibility over those things, and
28 then I suppose there are potentially knock-on effects that
29 might create that tension across education providers and
30 that frustration around needing to broker with different
31 districts.
32

33 The other part which you've been touching on is around
34 the connectivity between what is the need that we have for
35 our future workforce and, you know, if we think, "All
36 right, we can see we're really going to need to beef up
37 midwifery numbers out in that part of the state", what is
38 our proposal around how we would be wanting to prioritise
39 midwifery placements out in that part of the state, and
40 then what are the mechanisms we do that through formally in
41 partnership with education providers? I don't know the
42 answer to that.
43

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

1 workforce unit is those insights and intelligence and how
2 do we connect that back into our discussions with the
3 university providers through formalised ways, which then
4 drives our response.
5

6 So your example of Brewarrina, if we have that as
7 a really important issue, then yes, we want to allocate
8 students out there, we would need to make sure they have
9 supervision, and then we might need to put in place an
10 initiative or a targeted nursing cadetship to say, you
11 know, we offer four cadetships and if you agree to work
12 there for two out of your first three years of postgrad, we
13 will pay you. It's like they have done with the Rural
14 Doctors Network, with the medical cadetships, which have
15 shown to produce really good long-term outcomes in terms of
16 sustaining people in rural practice. I think 64 per cent
17 after 10 years are still working in MM3 to 7.
18

19 That was a longwinded kind of anecdote, but looking at
20 the bigger picture rather than just the allocation, which
21 currently is through ClinConnect, it's like a match-making
22 system, you know, the districts put in how many positions
23 are available, the universities go in and bid for them and
24 then there's an outcome and it is monitored through that
25 way. So that's just some thoughts.
26

27 MR MUSTON: In terms of that big picture that you speak of
28 and the extent to which clinical placements and all the
29 placements of students could potentially be used to address
30 workforce challenges, accepting that there will be
31 occasions when that won't work, that really has to happen
32 centrally, doesn't it, for it to work effectively, because
33 it is only the centre that has that visibility of the whole
34 system that can see?
35

36 Whilst there might be a lot of perceived need in each
37 of the different LHDs and they are all vying for
38 placements, as are the universities vying for placements,
39 but it's at the centre that you can look at it and say,
40 "Well, we, based on the information we have, think that
41 systemically the most appropriate way to distribute this
42 future workforce is as follows, today." Next month, next
43 year might be different.
44

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

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

9
10 I might see if Richard has a thought on that, if
11 that's okay. It is complex, but it is a conversation we
12 need to have, yes.

13
14 MR GRIFFITHS: I agree with you, I think, the value of
15 centralisation or central visibility is that, that you can
16 put that system lens over need and demand.

17
18 In terms of an approach, it really does need to be
19 a close collaboration with those health organisations,
20 though, because the service planning responsibility, while
21 there is obviously an overall visibility that the ministry
22 has in terms of service planning, that service planning
23 responsibility rests with local health districts, and
24 workforce obviously is an enabler to that. So it would
25 need to be a very close collaboration with local health
26 districts if we were to do a little more than what we're
27 doing at the moment, which is allowing them to tell us what
28 their capacity is.

29
30 I think the benefit of that sort of central visibility
31 would be we could probably press a little harder and
32 encourage more capacity than what we're doing at the
33 moment.

34
35 MR MUSTON: For example, by including it as a KPI that an
36 LHD has to meet, hypothetically?

37
38 MR GRIFFITHS: I think in coming to the decision around -
39 because that would be how we would enforce it, but I think
40 coming to the decision probably needs to be shared
41 understanding of system capacity.

42
43 MR MUSTON: Of course.

44
45 MR GRIFFITHS: So at the moment that probably doesn't
46 happen. It's very much the districts choose their student
47 capacity and we facilitate it through a centralised system.

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

3
4 MS DOMINISH: And I think there needs to be
5 acknowledgment, though, of you can set a KPI, and I know
6 we're talking about allied health this afternoon, but there
7 has to be a recognition that someone does have to pay for
8 the support that is being required for those students. So
9 whether that's the health system or the education
10 providers, there needs to be an acknowledgment of the
11 burden of taking students - and I don't mean this in a
12 negative way because it is absolutely part of our business
13 to educate the future workforce, I've taken lots of
14 students in my career and it is very rewarding, but we
15 can't do that in isolation of recognising the rapid growth
16 in the number of students and programs that have occurred
17 over the last six years, which has not matched the growth
18 of the health workforce.

19
20 If there aren't considerations for facilitators,
21 clinical supervisors, educators, those enabling functions,
22 to assist with increasing placement capacity, then setting
23 a KPI only will be - we won't be able to achieve that.

24
25 Jacqui, did you want to --

26
27 MS CROSS: I just wanted to add, I think there is an
28 assumption there that we need more, and given our supply of
29 nurses in particular, I think it's more about the
30 maldistribution example that you gave in that sort of rural
31 area and perhaps it is looking at how you can focus in on
32 them, rather than giving flat KPIs around the clinical
33 placements across the board.

34
35 Certainly I know the data around COVID, for instance,
36 we increased and maintained our clinical placements, and
37 certainly when I've provided information the deans and
38 heads of school have been quite positive about New South
39 Wales' ability to actually support clinical placements.
40 And I think again I said in my previous statement that we
41 actually also provide clinical placements for people who
42 are going to go into the private sector and into the aged
43 care sector as well, so taking that on board. I think it's
44 about thinking about what is the issue we're trying to
45 solve.

46
47 MR MUSTON: Can I ask a question about that in terms of

1 providing clinical placements for people who are going to
2 work into other sectors. Often, would it be the case that
3 the particular students don't have a plan to go into
4 another sector at the time that they're doing the
5 placement, that's just where their trajectory takes them?
6

7 MS CROSS: That's just where they go, yes.
8

9 MR MUSTON: Would part of that problem be ameliorated by
10 a wider-reaching version of Professor Baird's scheme in
11 North Sydney which actually provides for a student who has
12 conducted a placement in a home-based facility facilitated
13 by perhaps a central body like HETI - we will come back to
14 that - with an effectively guaranteed graduate position at
15 the end such that they can actually see that career pathway
16 into a facility, they might not spend their life working in
17 that facility but at least it would have them working there
18 from the get-go?
19

20 MS CROSS: I guess it will, yes. To me, when I think
21 about that model, it is about actually the preparation and
22 the pre-preparation and the socialisation, I guess, of
23 that. If you are looking at it from a workforce supply
24 point of view, I would argue that, as I said before, we
25 currently have enough students enrolled, particularly - and
26 we can attract them to all our metro areas, in fact we have
27 more than we need, so I suppose you have to think about it
28 in that way.
29

30 Coming back to my other point before, I think you just
31 need to be mindful about making sure that we don't decrease
32 the numbers that are coming through as well. So what is it
33 that we need, how do we manage that, access to other
34 universities within the same sites so we're not
35 disadvantaging other students as well, I think that needs
36 to be thought of too.
37

38 MS DOMINISH: I think just extending on what Jacqui said,
39 in principle, that sounds and looks like a great idea.
40 Breaking it down, there are enablers that currently exist
41 in every district for districts to employ AINs, which are
42 undergraduate nursing students, because we've got an award
43 that allows us to do that, and districts within their
44 budget capability can decide how many and where they are
45 and that the supervision is available for them.
46

47 The issue around equity in recruitment policy is one

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

9
10 There is a double-edged sword there, given that the
11 total number of nursing graduates, we can't employ every
12 single one of those I'm assuming, based on budget and
13 current capacity. That is something that we need to be
14 mindful of just in terms of a limitation around suggesting
15 this type of thing, even though in principle it sounds like
16 a good idea.

17
18 PROFESSOR BAIRD: Can I just interject and say, just to
19 clarify, THAT they would go through a recruitment process.
20 They wouldn't just be automatically given the position;
21 they would still have to apply and go through a recruitment
22 process.

23
24 MR WHAITES: One of the important things - where do we sit
25 on the whole centralisation/decentralisation question?
26 I think there is a role for both. There are times when
27 centralisation is really useful and important and times
28 when you need that decentralisation for that local
29 decision-making capacity to occur.

30
31 When you think about the student experience in the
32 workplace, I support the comment that was made that in the
33 smallest of places, there is just not the volume, the
34 capacity to do that.

35
36 One of the important things is making sure that you
37 have a workforce that has the psychological capacity -
38 I think that's poorly framed - but given the workload
39 pressures that our members talk about, the capacity to take
40 on a student and mentor them during their clinical day,
41 sometimes there is just not the brain space to do that,
42 right, because of the other pressures, particularly if you
43 are already working short or with a lower skill mix.

44
45 One of the key roles that exists within the award and
46 within the workplaces is that of clinical nurse educators
47 and clinical midwifery educators, and we know that at the

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

5
6 We know of a new graduate coordinator, that position
7 was defunded at a tertiary centre. One of the reasons why
8 we think that occurs is because the local budgetary
9 decisions that are being made are: is there a nurse and
10 a midwife at a senior operational level that is able to
11 influence those budget-making decisions? And too often
12 we've seen senior nursing and midwifery positions left to
13 having professional line responsibility rather than
14 operational line responsibility. So some of that
15 decision-making at the local level we feel would benefit
16 from more centralised processes or oversight, but I do
17 acknowledge the absolute complexity in trying to do that.

18
19 MS CROSS: Can I just clarify, the Nursing and Midwifery
20 Office don't fund those positions. The positions are
21 funded oftentimes through election commitments and the
22 like; we just administer how those positions are
23 administered and make sure that they're recruited to.
24 I just draw that distinction.

25
26 MR WHAITES: My mistake.

27
28 MR MUSTON: Doesn't that point to the possibility - this
29 is a question - that a central body like an appropriately
30 resourced HETI, for example, responsible for dealing with
31 student placements across the state and distributing
32 student placements across the state and ensuring that
33 appropriate resources are available at each local health
34 district and funded within each local health district to
35 deliver the experience that these students need, would be
36 a preferable system to a system whereby individual
37 institutions go with their own uniquely struck bargain,
38 "Maybe we'll pay you some money for a student, maybe we
39 will provide a supervisor here"; "Maybe providing
40 a supervisor is better than some money so we'll take this
41 university instead of that one", and also has the capacity
42 to distribute those placements and cadetships and
43 scholarships and whatever other tricks you might have up
44 your sleeve in a more strategic way, and potentially
45 graduate placements, acknowledging that not everyone can be
46 employed?
47

1 MR GRIFFITHS: There is definite advantage in it, yes, and
2 one of those advantages, obviously, is that you are going
3 to have a closer alignment to student against vacancy.
4

5 I think one of the things that we're not doing at the
6 moment is getting in and offering students who are
7 proceeding through degrees roles while they're studying;
8 we're waiting until they complete their degree. There's
9 probably an opportunity to try and secure some of those
10 graduates earlier in the process.
11

12 The challenge that we see is that districts decide
13 their graduate numbers the year before, so there is an
14 element of risk making decisions two years, three years out
15 from the vacancy arising, because obviously you have that
16 regular churn. But we're getting around that at the moment
17 by locking people in to agreement to work in certain
18 places.
19

20 The tertiary study subsidies program is an example,
21 where we prioritise some of those subsidies and offer them
22 on the basis that people will agree to work in some of our
23 areas of need like some of our rural centres. So we're
24 trying to overcome that through utilising some of those
25 mechanisms, and we know at the time that people accept that
26 they're well intended to work in those centres and that at
27 the time when they complete and we offer them a role, that
28 may change. But they are genuine, I believe, in agreeing
29 to work in some of our areas of need. But we don't get in
30 and do that early in the degree program, and I know that
31 some of our competitor sectors are doing that, they are
32 getting in an offering students roles early, before they
33 complete.
34

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

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

7
8 If we could look to reform some of that, it would be
9 great. It's just, as I said, there are 96 separate
10 institutions that we would be up against in terms of
11 unpicking some of those arrangements. And I know that some
12 of those institutions, as well, have longstanding real
13 estate arrangements in some of those facilities, so they're
14 going to be reluctant to let those go.

15
16 MR MUSTON: As one of those 96 institutions or at least
17 a representative of one of those 96 institutions, can
18 I explore with you Professor Baird the potentially
19 terrifying prospect of unpicking some of the arrangements
20 that your institution has worked hard to broker. What is
21 your view on the idea of centralising the student placement
22 program so that student placements, potentially graduate
23 positions and scholarships and cadetships, and a range of
24 other levers and incentives that might be applied at the
25 moment in the context of nursing and midwifery to deal with
26 maldistribution? Is that something you think would be
27 a positive or a negative, system-wide and from the
28 perspective of your institution, the answers could be
29 difficult.

30
31 PROFESSOR BAIRD: That's a really difficult question to
32 answer, simply because of the factors that some of the
33 other members of the panel have highlighted. It would be
34 a logistical nightmare to try to unpick all of that. But
35 I agree with Richard that should not stop us from maybe
36 looking at what might be an alternative way of placing
37 students.

38
39 For us I think we tend to focus on the acute area, and
40 we forget about the primary sector, and I feel that that is
41 an area that we could look at around placing students into
42 there. I am really interested in when the practice review
43 will be released - again, it's going to the minister
44 in October - that Professor Mark McCormack has been
45 leading, to look at scope of roles of people and how they
46 can work in the primary sector. So I think it isn't just
47 looking at is there a different way to do this; it's also

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

5
6 Certainly if you were thinking about rural areas,
7 that's an ideal area where I feel primary health care is
8 really important. I think you've got the conversation this
9 afternoon around allied health, but it also encourages
10 collaboration and co-working with other health
11 professionals in the primary health sector.

12
13 MR MUSTON: Can I ask you about the issue that
14 Mr Griffiths has raised about the metro-centric nature of
15 a lot of the placements, driven largely by the fact that
16 the large institutions like yours are metropolitan based.
17 What are the opportunities and challenges, as you see them,
18 associated with dispersing placements from an institution
19 like yours more widely across the system?

20
21 PROFESSOR BAIRD: I think it's cost. For the student,
22 too, in terms of finding accommodation. A lot of our
23 students might not be able to move into rural areas because
24 they've got family commitments. Nursing and midwifery
25 continues to be a female-dominant profession and we attract
26 students at all different ages, and some have families. So
27 asking a student to leave their family and move to a rural
28 area wouldn't suit everybody. But it's finding
29 accommodation for them to stay, you know, I think there are
30 financial constraints with that and that's where
31 scholarships would be really important.

32
33 Most students enjoy the opportunity of a rural
34 placement. The length of time might be a big factor. But
35 often we find when some of our students do go on a rural
36 placement, they really enjoy that placement and think
37 about, "Is that somewhere I could move my family to or is
38 that somewhere where I could work?" But there needs to be
39 more planning and thinking around how we would support
40 a long-term placement in a rural area for a student that
41 lives in South West Sydney and what that would mean.

42
43 MR MUSTON: Could I also ask you a question Mr Griffiths
44 raised earlier, about what he perceives to be value in
45 trying to identify in a more common way what the student
46 experience, delivered through a placement, should be.
47 I inferred from that that different institutions might have

1 subtly different views about that. First of all, is that
2 inference right in the sense that is the student experience
3 to be delivered through a placement something which is
4 driven by a particular course structure and syllabus at one
5 institution which might be different subtly to another?
6

7 PROFESSOR BAIRD: It shouldn't vary too much because we
8 all have to follow the accreditation standards set down by
9 our professional body and each program that is accredited
10 and reaccredited through the Nursing and Midwifery Board of
11 Australia, through ANMAC, our Australian Nursing and
12 Midwifery Accreditation Council, all have to meet the same
13 standards or the program does not get accredited. The
14 learning objectives should be the same for every single
15 student regardless of what university they come from, so
16 that should not be an issue. How that institution might
17 deliver those standards might vary, but we should all be
18 delivering the same programs of education in nursing and
19 midwifery.
20

21 MR MUSTON: Is there scope, to pick up on a suggestion
22 that Mr Griffiths made, for institutions, including yours,
23 to come together with the ministry and settle upon, in
24 effect, a common way in which those experiences are
25 delivered through the placement program so as to enable
26 there to be certainty and perhaps even portability of
27 students from different institutions and different LHDs to
28 the extent that that might be possible and desirable?
29

30 PROFESSOR BAIRD: We would welcome any conversation that
31 might happen around future student placements, absolutely,
32 but until we would know what that would look like, it would
33 be hard to comment on what the outcome might be.
34

35 MR MUSTON: Not wanting to sound like a broken record, but
36 would that process be better facilitated by a centralised
37 process dealing with the allocation of placements than,
38 say, individual arrangements between institutions and LHDs?
39

40 PROFESSOR BAIRD: Again, that's hard to predict until we
41 would know what that would actually look at. Certainly at
42 the university we have longstanding relationships that we
43 have built up and we highly value those relationships, as
44 we do with our relationship with the ministry, so we would
45 be happy to be involved in any future dialogue around
46 student placements.
47

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

2

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

13

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

22

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

34

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

45

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

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

6
7 PROFESSOR BAIRD: I think that is a problem if you've got
8 two or three universities all going to one hospital, that
9 nursing and midwifery educator or nurse midwife has to have
10 some form of clarification around what year is this student
11 currently at and what level should I be assessing for that.
12 But again, that information is there to support them in
13 making that assessment.

14
15 Probably why relationships are really important is
16 they will pick up the phone and they'll say, "I have
17 a concern about a student", and we'll just talk, you know,
18 we'll talk that through.

19
20 I have to say we feel our students are very well
21 supported in clinical practice, both in nursing and
22 midwifery. We have no concerns in that area. But it can
23 be challenging if you've got several universities and the
24 students all want to be out in the clinical practice at the
25 same time, and that might need some negotiation to make
26 sure that the staff aren't overwhelmed with too many
27 students. So it is, as I said earlier, a bit of a jigsaw
28 puzzle and it can be a bit of a logistic nightmare for some
29 of our hospitals trying to manage student placements.

30
31 MR MUSTON: Ms Dominish, you were going to make a comment.

32
33 MS DOMINISH: Yes, I think throwing the cat amongst the
34 pigeons a little bit, the concept of the scheduling is
35 definitely something that is a challenge for the health
36 service, due to the ebbs and flows of activity and
37 pressures of winter and all of those kinds of things that
38 occur across the year. But even within each discipline,
39 having universities placement blocks kind of all over the
40 year in different ways is a challenge.

41
42 Again, not an easy solution because it is a jigsaw
43 puzzle, but certainly in other states - there is an example
44 in physiotherapy in Queensland where they managed to get
45 every university to agree to the same placement blocks and
46 they all run at the same time every year, so that the
47 service is really prepared and understands when things

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

7
8 MS CROSS: Just on that, too, I think around when they can
9 be scheduled as well. So certainly with things like night
10 duty, I know some of the districts are interested in being
11 able to support students on night duty because that's real
12 life for a nurse, and how do we sort of work through that
13 with the universities as well.

14
15 MR WHAITES: The comment I was just going to make is
16 I can't disagree with any of the points and the problems
17 that have been outlined there, but when you're looking at
18 the question of maldistribution, the major regional
19 hospitals have university relationships, have their
20 students coming and going. The opportunity for those
21 students to go into minor regional hospitals, the remote
22 hospitals, the economic barrier faced by the students
23 themselves is the hurdle to overcome.

24
25 It used to be that hospitals had nursing accommodation
26 attached to them. Economic rationalism got rid of all of
27 those. For a student to be able to afford transport to the
28 site, accommodate themselves, feed themselves on top of the
29 university course costs, no amount of coordination and
30 centralisation is going to fix that unless you fix the
31 student poverty or provide those as part of the student
32 experience.

33
34 MR GRIFFITHS: I don't disagree. The other thing is, in
35 looking at student placements, you need to consider how
36 wide you go, because, as I said before, we're not the only
37 provider of training for student placements, and for us
38 it's a \$350 million operation each year. We get some of
39 that back, but we're still in the vicinity of \$150 million
40 to \$200 million it costs us, and I will sort of put two
41 positions forward. One is that we're wearing the burden of
42 training for our competitors, at the moment. There is
43 training that occurs in those sectors but the bulk occurs
44 in the public system. Some will say, "Well, that's your
45 role as the public sector; you are the training
46 organisation." But on the other hand, if you're going to
47 do a review of student placements in the health system,

1 that then - I will use the term "unfairly" - sort of swings
2 people into the public sector, you then starve the other
3 sector of supply.
4

5 So I think if you really want to look at it, it's
6 bringing those sectors to the table as well. So we're
7 losing workforce at the moment, for example, to NDIS, to
8 aged care and to private health. There's no reason why
9 those sectors couldn't be in the training - and they are,
10 to a degree. But I think whatever you do, you need to take
11 into account what the impact is going to be for those
12 sectors as well, because it could unfairly impact them by
13 moving students across into the public sector.
14

15 MR MUSTON: In what way are they moved across into the
16 public sector? If the idea is just a greater coordination
17 of the existing students within the public sector, how does
18 that impact on the private sector?
19

20 MR GRIFFITHS: If you have a blue-sky sort of picture
21 where we've student experience so fantastic in the public
22 sector they're only going to work with us and we end up
23 making it difficult for our competitor sectors. There is a
24 little bit of an altruistic type of contribution that we
25 make to the sector because we are the public sector.
26 I just think that if we're really serious about it, and if
27 we're going to do unpicking, then we probably have to
28 factor in those other sectors as well.
29

30 MR MUSTON: Can I move away from the student placement
31 experience and just ask a couple of questions about the way
32 in which workforce data, the available workforce data, is
33 used in recruitment. Again, recruitment, as I understand,
34 is done largely in a devolved way, so a particular facility
35 in a particular LHD needs a nurse or a midwife, they will
36 enter the market to try and find one.
37

38 MR GRIFFITHS: Correct.
39

40 MR MUSTON: And there may, at any particular point in
41 time, be more positions advertised for, say, midwives, for
42 example, than there are people wanting or able to apply for
43 those jobs.
44

45 MR GRIFFITHS: Yes.
46

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

1 me take it back a step. To what extent, if any, so far as
2 you're aware, is the workforce data that you have available
3 centrally utilised in decision-making about where to be
4 offering positions, particularly in areas of extreme
5 shortage, like midwifery?
6

7 MR GRIFFITHS: The exception to what you have said there
8 is new graduate recruitment, which is centrally recruited.
9

10 MR MUSTON: Just pausing there, when you say that new
11 graduate recruitment is centrally recruited, how does that
12 actually operate in terms of deciding whether or not
13 a graduate midwife goes to Cooma as opposed to North Shore,
14 for example.
15

16 MS CROSS: The districts still put the positions up that
17 they want to recruit to. So it's still determined by the
18 districts.
19

20 MR MUSTON: It is just the process of recruitment happens
21 centrally so you make one application for multiple roles?
22

23 MS CROSS: Yes, and we filter them out to the districts.
24

25 MR GRIFFITHS: Sorry, the second part of your question?
26

27 MR MUSTON: The second part of my question was to what
28 extent, let it be assumed that there's - pick an easy
29 number - 10 midwife positions available across the state,
30 whether it be graduate or more experienced people. There
31 are five people who are applying for them. To what extent,
32 if any, is the workforce data you have about immediate
33 workforce needs and projected workforce needs taken into
34 account in deciding where those positions should be offered
35 and filled?
36

37 MR GRIFFITHS: Well, it's definitely devolved, at the
38 moment. The local health districts are making decisions.
39 If you're going to utilise a central coordination process
40 to really influence some of those appointments, you have to
41 turn off some recruitment in an area so that the only
42 available position is the one that you want to fill, which
43 we don't do at the moment. So the districts really take
44 responsibility for filling their staff establishment.
45

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

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

6
7 MR MUSTON: Is there any utility in a more centralised
8 approach to recruitment? That's probably a very broad
9 question. From the point of workforce distribution as
10 a first lens, is there an advantage, do you think, to
11 centralising the recruitment process in that way?

12
13 MR GRIFFITHS: I'm just trying to think through what it
14 would deliver. The process is standardised, so even though
15 it's not centralised, it's standardised across the state.
16 Whether we could influence positions more so than what the
17 districts are doing, I don't know, because really, we're
18 trying to do that through offering incentives in certain
19 areas. It is really up to the person to apply to where
20 they would prefer to work.

21
22 Under our Act we can't just move a person and directly
23 appoint them where they need to be, unlike some of the
24 other services. So if we were to move down that type of
25 path, then you could really influence the pipeline and
26 directly appoint them to where they need to be appointed,
27 with appropriate sort of conversation.

28
29 The challenge that we have at the moment is that we
30 can't force people to go in a particular place. We
31 encourage it, we incentivise it, we probably need to do a
32 little more in selling some of the rewards of those
33 incentives.

34
35 For example, in our incentives program, we've got the
36 capacity to incentivise a transfer. We haven't done one
37 yet, and it's only a new policy, so it's making sure that
38 people understand that facility is there. The way that
39 that would work is for some of those very challenged areas,
40 ahead of the person accepting a role, they could negotiate
41 a term out there, say two years, and in return, they could
42 basically pick a hospital where they wanted at the end of
43 that term, similar to the points system that the education
44 system used to run, or still do to a degree.

45
46 That might encourage people to go to some of those
47 areas, knowing that they've got the capacity to get

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

6
7 MR MUSTON: In terms of the centralised recruitment
8 process as a possibility, does it also have an additional
9 benefit, a similar upside to the graduate recruitment
10 process, where however many positions there might be
11 available out there in the health system, you fill out one
12 application form, you tick the boxes that identify which
13 particular positions you might be interested in,
14 accreditation in terms of your skills and your
15 qualification to do any one of those jobs is dealt with
16 once and centrally rather than each LHD receiving
17 a separate application, going through each of those
18 processes separately?

19
20 MR GRIFFITHS: We do that to a degree for new grad nurses,
21 for JMOs.

22
23 MS CROSS: New graduates are able to prioritise where they
24 want to go, say if it's 1 to 8, if they get their first
25 preference they are interviewed there, but if they're not
26 successful then they go into an eligibility --

27
28 MR MUSTON: That works for the graduates. What I had in
29 mind was more once you've gone through that graduate
30 process and you may be 10 years into your career, you say
31 "I would like a job. There's one in Brewarrina, one in
32 Wagga, one in Dubbo, I'll take any one of those jobs
33 because I might not get to choose, so I will have to apply
34 for all of them", which potentially has you filling out
35 multiple applications, being accredited across at least two
36 local health districts, potentially having things like your
37 working with children checks and all those sorts of things
38 having to be done twice. Is there some utility in
39 centralising that in a way that means the actual
40 recruitment process is streamlined to reduce - whilst
41 people might still identify where they want to go out there
42 in the system, they may not be having to effectively run
43 their own race with each individual position and each
44 individual facility?

45
46 MR GRIFFITHS: Yes, there would be utility in that and
47 there are things that we're doing moving towards that type

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

11
12 Local health districts don't want to lose their
13 autonomy of choosing their workforce as well because that
14 culture fit assessment is very important. So there does
15 need to be some element of recruiting managers being able
16 to pick. But we're designing a process that sort of brings
17 about a better candidate experience, because that is
18 feedback that we've heard, that our processes are complex
19 and not particularly candidate friendly. I know that we're
20 not alone, though, in that. I know that our competitors,
21 their processes are equally as candidate unfriendly.
22 However, we know that that's going to have to be work that
23 we do in order to improve our value proposition.

24
25 MR WHAITES: We get a lot of feedback from members who are
26 managers, members who are going through the employment
27 process, and NSW Health unfortunately has a reputation for
28 being slow, people, as you say, putting in multiple
29 applications looking for work and often the private sector
30 is quicker, from interview to phoning them up to say
31 "You've been successful. When can you start", and that
32 on-boarding. I think it does vary, depending on the LHDs,
33 but certainly there is more work to be done there, yes.

34
35 I think one of the comments about the incentive
36 schemes that both the government and ministry have brought
37 in - you can understand why they're doing those things, but
38 there are unintended consequences. Whilst you might
39 support the \$20,000 bonus sign-on to become a midwife in
40 rural New South Wales, for the midwives that are already
41 working there, that's, you know, an undervaluation moment
42 from their perspective, and we see the application of those
43 incentive programs causing some tensions within the
44 workplace as one group gets the retention or bonus and
45 others don't.

46
47 So they are useful but we think there needs to be more

1 work there, and, of course, we would go back to that
2 central message of, you know, we know that nursing and
3 midwifery has the highest proportion of ads placed out for
4 vacancies but the lowest amount of people applying for it.
5 I think SEEK reports nursing as being their highest
6 disparity. You would assume if economic rationalism and
7 the market forces were playing out appropriately, then the
8 wages would be driven up and that would take care of
9 itself. I think, you know, wages generally are the
10 approach to getting some of that maldistribution, even if
11 you are looking at - for instance, there is an allowance..
12 if you work out at Broken Hill, there is an allowance that
13 kicks in against an imaginary line drawn through the state.
14 Whether or not we review that in the longer term as to how
15 that might encourage people to relocate is another option.
16

17 MR MUSTON: I note the time. I was going to ask one last
18 question about scope of practice, if I could. From the
19 point of view of, to pick up on I think a term Mr Whaites
20 used, "value" and the extents to which you are valued in
21 your workplace, does ensuring that every layer of the
22 workforce or every contributor to the nursing and midwifery
23 workforce is able to work at the top of their scope as best
24 as possible and not be overly burdened by things which
25 might be at the bottom of their scope, does that enhance
26 your recruitment and retention particularly to areas where
27 maldistribution is biting?
28

29 MR WHAITES: Yes, I think absolutely, particularly in
30 certain areas. Midwives talk a lot about desire to work
31 more autonomously and certainly their scope of practice
32 allows for that. The ability for more positions around
33 nurse practitioners or advanced practice nurses, so that
34 people see a career progression for them and a growth in
35 their clinical area of application certainly makes work
36 more satisfying. It is not just nursing and midwifery,
37 there's so much evidence around that as a way to get people
38 engaged in their profession.
39

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

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

15
16 MR MUSTON: And potentially another reason why a slightly
17 greater centralised control of the student placement
18 process might be a good idea, possibly.

19
20 MS CROSS: I'd say it is about the workforce we already
21 have, too.

22
23 MS DOMINISH: I think the benefit of that - well, we don't
24 want to deskill people the minute they graduate. So we
25 have to do, as Jacqui's highlighted and Michael mentioned
26 too, some work I think particularly with nursing and
27 midwifery to accelerate where are those high-value
28 opportunities that we're not taking advantage of and are
29 there things that we are deskilling people in immediately
30 on graduation - so Jacqui's example of cannulation and
31 venipuncture, nurses are trained to do that in their
32 undergraduate training but why is it they are not perhaps
33 doing it in the system when they should be? We don't want
34 to expend money retraining people for things that they have
35 already been trained to do. But equally with the pressures
36 of the system, what are the high volume, high value
37 activities where nurses could really bring - and midwives -
38 their capabilities?

39
40 The recent piece of work that has been done for the
41 emergency department, and I know it has been talked about
42 in evidence, the ECAT protocolised care, really enhances
43 the ability of nurses in the ED to optimise their scope of
44 practice in that setting. The reward for a clinician is it
45 may not be something completely complicated but it means
46 you get an instant satisfaction from the patient's
47 experience that they're not having to wait around for

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

6
7 MR MUSTON: I note the time, Commissioner. I think that
8 probably exhausts our discussion about nursing and
9 midwifery this morning, unless you had any other issue you
10 wanted to raise or any of you had any other particular
11 burning issue that you wanted to raise.

12
13 MR WHAITES: Just one other quick comment. When we talk
14 about scope of practice - as Jacqui said, we talk about the
15 various levels - we also can't forget some of the
16 fundamentals of nursing and midwifery, in particular,
17 nursing, where we often see another classification of
18 worker brought in or attempted to be brought in in order to
19 take on what we say are nursing duties.

20
21 One of the fundamentals for that is showering
22 a patient, as an example. A registered nurse will tell you
23 that's the moment where they're doing a gait assessment,
24 where they're doing a skin integrity assessment, they're
25 looking at the person's capacity to attend to their own
26 activities of daily living. This all forms part of the
27 holistic approach that nurses take to the patient care that
28 they are providing.

29
30 It's not as simple as the very high-end stuff where we
31 talk about endorsed midwives or nurse practitioners, that
32 middle level stuff about cannulation, when you look at the
33 scope of practice for nurses, they really are an absolute
34 value-add to the hospital system, because of their breadth
35 and scope.

36
37 MS DOMINISH: I would agree.

38
39 MS CROSS: And I think the other bit that we don't capture
40 very well is that the essence of what we do is about that
41 evaluation and assessment, and we're doing that in all
42 sorts of ways and all sorts of times, when we're showering
43 a patient, putting that cannula in, when we're talking to
44 their family. So we don't actually capture that well and
45 I think that's the fundamental part of what we do.

46
47 MR MUSTON: Do I take it from that that one would need to

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

8
9 MS CROSS: And it is about how the whole team come
10 together.

11
12 MS DOMINISH: I think nurses and midwives are the only
13 people who really see patients at every hour of the day.
14 They see them through that cycle of in the middle of the
15 night when things are falling part, or first thing in the
16 morning, they can see their change in behaviour and their
17 change in function, so, yes, agree that that value should
18 be well recognised.

19
20 THE COMMISSIONER: I have some questions on the new
21 statements. It is actually from the new statements of
22 Mr Griffiths and Ms Dominish, so perhaps we can do it as
23 part of the next panel, because they're coming back. That
24 might be the easiest thing.

25
26 MR MUSTON: Sure.

27
28 THE COMMISSIONER: All right. We will adjourn until
29 10 past 2. To Mr Whaites, Professor Baird and Ms Cross,
30 thank you very much for your attendance. We're very
31 grateful for your assistance today and we'll come back with
32 the next panel at 10 past 2. We'll adjourn until then.

33
34 <WITNESS WHAITES WITHDREW

35
36 <WITNESS CROSS WITHDREW

37
38 <WITNESS BAIRD WITHDREW

39
40 LUNCHEON ADJOURNMENT

41
42 MR MUSTON: The second panel for the day, from your left
43 to your right, we have Professor Newton-John, head of
44 allied health at UTS, Professor Debra Anderson, the dean of
45 health at UTS, Richard Griffiths, who we already know, and
46 Jacqueline Dominish, who we already know from this morning.
47

1
2 <TOBIAS ROBERT OLIVER NEWTON-JOHN, sworn: [2.11pm]
3
4 <DEBRA JANE ANDERSON, sworn:
5
6 MR MUSTON: Professor Newton-John, could you state your
7 full name for the record, please.
8
9 PROFESSOR NEWTON-JOHN: Tobias Robert Oliver Newton-John.
10
11 MR MUSTON: Professor Anderson, could you give us your
12 full name, please.
13
14 PROFESSOR ANDERSON: Debra Jane Anderson.
15
16 MR MUSTON: Both of you have participated I think in the
17 preparation of a statement prepared on behalf of the
18 University of Technology dated 1 October 2024?
19
20 PROFESSOR ANDERSON: Yes, that's correct.
21
22 PROFESSOR NEWTON-JOHN: That's correct.
23
24 MR MUSTON: You have had an opportunity to review that
25 before coming to give your evidence today?
26
27 PROFESSOR NEWTON-JOHN: Yes we have.
28
29 PROFESSOR ANDERSON: We have.
30
31 MR MUSTON: You are satisfied that its contents are, to
32 the best of your knowledge, true and correct?
33
34 PROFESSOR NEWTON-JOHN: Yes.
35
36 PROFESSOR ANDERSON: Yes, we are.
37
38 MR MUSTON: Commissioner, that's at document L18.
39
40 Can I start by perhaps asking you,
41 Professor Newton-John, what you see as the significant
42 workforce challenges as they apply in the allied health
43 space?
44
45 PROFESSOR NEWTON-JOHN: Workforce challenges in the sense
46 from the university perspective?
47

1 MR MUSTON: From the university's perspective, in terms of
2 feeding allied health students, then graduates, into the
3 workforce to make up part of the public health workforce.
4

5 PROFESSOR NEWTON-JOHN: There are number of constraints,
6 obviously, and one of them top of mind is the clinical
7 placement situation. In a number of our disciplines we
8 have quite a number more applicants than we have places to
9 give to students, and there are obviously a number of
10 reasons, limiting factors there, but the lack of
11 availability of clinical placements for many disciplines is
12 a major one, and so the opportunity for us to expand our
13 courses and train more allied health professionals is
14 dependent on those students being supervised in the field,
15 and the availability of field supervision places is very
16 limited in a number of our disciplines.
17

18 MR MUSTON: Do you get the sense, and perhaps this is more
19 a question for you, Mr Griffiths, that within the allied
20 health disciplines, and again break them down if you need
21 to, there are sufficient graduates being produced to meet
22 workforce, present and future workforce needs, or is there
23 a disconnect?
24

25 MR GRIFFITHS: There is a bit of a shortfall. The
26 modelling has shown that even some of the areas where we
27 were more comfortably supplied, because of the NDIS, we're
28 now seeing shortages - so physios, OTs, social workers. So
29 it's hard because it's a group of 23 separate disciplines,
30 but on the whole, most of those disciplines now are
31 challenged in terms of supply.
32

33 MR MUSTON: And picking up on a discussion this morning,
34 in relation to the ability of the public health system to
35 provide placements for students in these disciplines,
36 particularly in areas of need, are there things that could,
37 in your view, be done differently to increase the number of
38 student placements that the system is able to offer to
39 students?
40

41 MR GRIFFITHS: Again, further to the conversation we had
42 this morning, I think so. I think there are opportunities
43 that we perhaps influence the system to create some
44 additional capacity.
45

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

1 may not have the supervision to support the student during
2 the placement. Metro is a little easier because we don't
3 necessarily see that fractionated appointment in Sydney.
4

5 I think there is an opportunity for us to perhaps
6 become a little more involved in influencing the capacity
7 across the system.
8

9 MR MUSTON: Coming back to you, Professor Newton-John, do
10 you, from the position that you occupy, have a sense of
11 whether the placements dictate or drive people to
12 employment in particular areas?
13

14 PROFESSOR NEWTON-JOHN: Yes, actually, quite strongly.
15 I've been interested in this for some time in terms of
16 where our graduates, our new graduates, get their first
17 job. We have alumni groups, so we can follow this up, and
18 it's more the case than not, actually, that students will
19 get their first position from a clinical placement they
20 have had, and that has been enormously valuable, both to
21 the student, of course, and to the employer. I'm talking
22 about not just in health but private practice as well -
23 it's across the different environments. But students who
24 have the opportunity and the employer who has the
25 opportunity to test each other out, to experience the
26 workplace, to experience the quality of the student, if
27 there's a position going, it's a natural sort of extension
28 then to employ that student.
29

30 MR MUSTON: With the placements, do the placements that
31 allied health students from your institution, for example,
32 take up - are they divided across the public and non-public
33 system?
34

35 PROFESSOR NEWTON-JOHN: They are, yes.
36

37 MR MUSTON: What sort of places do students tend to go for
38 their placements?
39

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

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

5
6 MR MUSTON: From the university's perspective, what is the
7 process that the university engages in to secure placements
8 for students within the allied health space?

9
10 PROFESSOR NEWTON-JOHN: It varies according to the
11 discipline, and there are many of them, of course, but if
12 we take clinical psychology as an example, generally, it
13 comes down to our clinical placement coordinator reaching
14 out to the profession and asking, "Does anyone have any
15 capacity to supervise one, two, or X number of students?"
16 There's a negotiation that takes place between that
17 individual potential supervisor and the university. It can
18 often hinge on sort of the loyalty that that supervisor may
19 have to the institution or whether they have got
20 a particularly busy semester or busy work period. It's
21 actually pretty ad hoc and we're often finding ourselves
22 left short in that it's very difficult to predict how many
23 clinical placement positions you will have for any one
24 discipline. So it tends to operate on the basis of
25 individual connection between a placement coordinator and
26 the facility offering a placement.

27
28 MR MUSTON: This might be a question for you,
29 Professor Anderson, given your likely oversight over both,
30 but is the placement and securing of placements within
31 allied health, different to the securing of placements in
32 nursing and midwifery, for example?

33
34 PROFESSOR ANDERSON: Yes, it is. So what we see is that
35 I think nursing and midwifery has been doing this a bit
36 longer and has a more sophisticated - what I would say is
37 a sophisticated approach. I think that's just because of
38 the historical nature and the broad scope that we've looked
39 at across other states across Australia and looked at
40 models there.

41
42 But what we do find with allied health and as we bring
43 on new allied health, for example, last year we started
44 with a bachelor of psychology, we find ourselves really in
45 a different situation of really relying on partnerships to
46 be able to kindly provide us with clinical placement, so
47 there is a lot of negotiation that has to take place,

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

8
9 We have now been working with those health districts
10 to negotiate, for example, exercise physiology placements,
11 for the first year, we were able to put them into clinical
12 placements within the local health district; psychology,
13 speech pathology. So those are the types now. We're
14 trying to look at will those models work as well. So it is
15 a bit different.

16
17 MR MUSTON: Ms Dominish, I think you were wanting to add
18 something.

19
20 MS DOMINISH: I think going into this conversation, it's
21 probably useful for me again to paint the context of allied
22 health and how this differs from nursing and midwifery and
23 medicine, particularly around the history and the structure
24 and function around clinical placements.

25
26 So at a fundamental level if we just look at the
27 workforce for allied health, and the way we work in the
28 district, so I will start with as a profession. So the
29 majority of allied health professionals, your whole
30 training is done in your undergraduate space. So not like
31 medical, when you finish and then there's ongoing levels
32 and training that are structured and there's infrastructure
33 that pushes you through up to your consultant level; for
34 allied health, those four years - it is generally four
35 years that you undertake in your undergraduate degree - is
36 what then gives you your licence, whether it is through
37 general registration or through the recognition of the
38 qualification to practise independently. The practice of
39 allied health professionals --

40
41 MR MUSTON: Pausing there, are there some allied health
42 areas where you get your undergraduate degree but in order
43 to get your licence, to use your term, you need to have
44 a postgraduate qualification? I think psychology might be
45 one of those.

46
47 MS DOMINISH: Correct, yes. Psychology is a part of

1 difference, also pharmacy has an internship year, and
2 professions like genetic counselling also require
3 additional exams and placements in order to sort of get
4 your full ticket to practise.
5

6 But once that is completed, the way an allied health
7 professional practises is independently, and generally
8 one-on-one with a patient. So we don't work in a
9 hierarchy, we don't have teams of people that work around
10 us, and when you're working in rural areas - like, you are
11 on your own. You are a sole practitioner.
12

13 What Richard was mentioning before - so that's the
14 training for allied health, and then the way you get better
15 and you specialise and you get more skilled is through luck
16 of the draw, through ad hoc professional development
17 courses, experience and moving around different positions
18 in the system and specialties.
19

20 In terms of the FTE and the way we're employed in the
21 system, unlike nursing and midwifery and medicine, we don't
22 have agency workforce, we don't have - I'm saying "we"
23 because that's my foundational discipline, it's a bad
24 habit. Allied health doesn't have agency, they don't have
25 locums, and very few districts have reliable casual pools.
26 So from a workload perspective, when there are shortages or
27 we can't fill positions, the existing staff will carry the
28 workload. So there is no ad hoc bring someone in on
29 a shift, get someone in to help with the workload, and
30 that's important because when you are looking at the
31 ability to take students on clinical placements, you don't
32 have that back-up in support for the clinician and their
33 day-to-day clinical work.
34

35 The final thing I want to say is that, looking at
36 nursing and midwifery, for student placements in nursing
37 and midwifery there are dedicated facilitators of
38 placements that are funded by the universities to enable
39 the student placements to occur and for the students to be
40 supported on top of coordinator roles in the districts.
41 That is in the context of also nursing having clinical
42 nurse educators, which we spoke about this morning, which
43 is the support for the professional staff, the qualified
44 staff, and they also support those qualified staff in their
45 skills and capabilities and confidence in being able to
46 supervise students and other more junior staff.
47

1 So I think it's just important to paint the picture of
2 the infrastructure that exists in other professions
3 compared to allied health.
4

5 I can talk a bit more about the educators and things.
6 In the allied health context, then - and there's a report
7 that has been attached to Richard Griffiths' statement,
8 which the ministry has just done, part of my team, around
9 allied health educators, and I suppose the concern that
10 exists around the lack of the number of educators that have
11 grown over time, and it has really been dependent on
12 individual districts deciding to invest in those roles and
13 it is very ad hoc.
14

15 The challenge for allied health also is you couldn't
16 have a social work educator trying to lead clinical
17 practice and supervision of pharmacy. Like, they are
18 totally different professions. And so in building that
19 capability, there needs to be consideration for what is
20 required for the size of the profession at a local level in
21 addition to, perhaps, smaller professions that might
22 require a higher level state-wide approach because of size.
23

24 So there hasn't been, to my knowledge, any centralised
25 investment in allied health educators since the Garling
26 inquiry, and that was specifically around pharmacy. There
27 was some investment there due to the need to support novice
28 professionals transitioning to the workplace and the
29 critical importance of medication and medication safety.
30

31 But other than that, it's a challenge, because if
32 we're wanting to increase placement capacity, which I think
33 there is goodwill from the allied health workforce to do,
34 there has to be recognition that that comes at a cost from
35 a wellbeing, a capacity and a financial perspective, and
36 because there's no consistent approach to that or
37 recognition of that, and you add that on top of not being
38 able to back-fill vacancies, or fractional appointments in
39 rural areas, where you may not even have a supervisor
40 workforce available - I just think it's important that it
41 is painted as a different context to the other professions.
42

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

1
2 MR GRIFFITHS: It's scale.

3
4 MS DOMINISH: It's scale. It is, I think, potentially -
5 you know, I suppose it's profile and who makes the most
6 noise and over time where the priorities have been put.

7
8 Obviously nursing is a big workforce and there's
9 a history around the structure of nursing which has evolved
10 over time, and perhaps it's just not been the visibility
11 and, I suppose, level of importance that has been placed on
12 that, either from a central level, both in the health and
13 education sector as well as the local health district
14 level. And I think now is a critical point, because we're
15 seeing severe shortages, particularly in professions like
16 radiation therapy, we're very worried about podiatry, OT,
17 the bottom fell out of OT during COVID when the NDIS hit
18 its full scale. So really, if we want to address this,
19 that has to be part of the conversation around what is the
20 support that is being provided for the clinicians.

21
22 The other point I would make is that in addition to
23 the clinical - you've got your health professional educator
24 roles and then you've got your student educator roles and
25 sometimes they can be discipline specific. I gave the
26 example around pharmacy and social work, and sometimes
27 generally in the qualified workforces we do have some
28 general educators across professions, but the levers that
29 we have available to us in New South Wales, there is not
30 anything built into the award around things like payments
31 for student supervision. So in Queensland, that has been
32 built in to their award. We haven't had the investment or
33 recognition of the importance of clinical educator
34 workforce.

35
36 And then there's also things like allied health
37 assistant positions, which we do have the ability to employ
38 people as allied health assistants from an award
39 perspective, where we could bring people studying into
40 those roles, like we spoke earlier today about nursing -
41 again, it comes down to where does the budget go and what
42 is the priority.

43
44 So there's a number of things we could do, but it's
45 really about what are the priorities and where does that
46 investment go.

47

1 MR MUSTON: Mr Griffiths or Ms Dominish, in terms of the
2 need for that investment, if it is not made and things
3 remain in the status quo, what is that going to do in terms
4 of the adequacy of the health service, in particular its
5 ability to deliver the allied health care that presumably
6 is an important part of any public health system?
7

8 MS DOMINISH: I will just make one comment and maybe pass
9 to Richard. Twofold. One is the ability for us to train
10 that future workforce and to do it in a way that is robust,
11 that's evidence based, that gives them the skills that they
12 require and transitions new graduates to practise in a way
13 that they can immediately make a contribution; then,
14 secondly, for our professional workforce, is ensuring that
15 what we're doing when we're talking about optimising scopes
16 and practice and changing models of care and adapting to
17 the way that we are delivering service, there is no doubt
18 that the role of allied health professionals in the future
19 workforce is critical with the complexity and
20 multi-comorbidities that people have, so we're at
21 a critical point in time where we need to look at this
22 I think more closely, about what our response is going to
23 be, to future-proof what we're doing.
24

25 MR GRIFFITHS: The only thing I would add to that is, we
26 need to do something, because the modelling is suggesting
27 that we need to invest each year in additional grads in
28 order to meet demand. So we do need to do something, and
29 as I interjected in Ms Dominish's evidence just beforehand,
30 the issue is scale, with allied health, which presents some
31 operational difficulty for us because you've got about the
32 same number of allied health practitioners as you do
33 doctors, but you've got to divide that by 23 disciplines
34 and then divide that by 17 organisations. So the spread is
35 very thin and a lot of those appointments, because of the
36 nature of the activity, are parts of an FTE, so
37 a fractionated appointment.
38

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

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

3
4 PROFESSOR NEWTON-JOHN: Yes.

5
6 MR GRIFFITHS: So we know that we need to do something
7 along those lines, but we need to do it in a way that's
8 sustainable because of the nature of the spread of allied
9 health.

10
11 The other thing we worry about is I don't know that we
12 really have a true picture of allied health demand, because
13 if there is no service to refer to there won't necessarily
14 be a stat that we can capture. That referral information
15 will be missing, because there's no-one to refer to.

16
17 MR MUSTON: So I can understand that, you might have the
18 absence of a speech pathologist in a particular LHD, which
19 means people aren't being referred to the LHD's speech
20 pathologist, which means you don't have data saying, "Here
21 is the number of people each day, week, month, who are
22 being referred to this is service", but that doesn't mean
23 there's not demand --

24
25 MR GRIFFITHS: Correct.

26
27 MR MUSTON: -- it just means that it's demand which is not
28 captured by your internal systems.

29
30 MR GRIFFITHS: That's right. We need to do a much deeper
31 dive into the activity to try to determine what the demand
32 is for allied health. It's probably a little bit of an
33 elastic commodity in a way: if you build it, they will
34 come. But the absence of that is the same in reverse: if
35 it's not there, it's not going to exist in terms of
36 referral data.

37
38 So we know that we need to do something different.
39 We've got to look at incentivising allied health graduates
40 into the health system, but as I said, the challenge is
41 doing it in a way that's sustainable.

42
43 MS DOMINISH: Just to add to that from the conversations
44 we've had with the allied health deans - when I say "allied
45 health deans", it is not like nursing and medicine where
46 there is one person in every place you go to. If you're in
47 the University of Sydney there are three, four or five

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

8
9 That relationship, particularly in allied health,
10 because it is often very one to one, between the student
11 and the clinical supervisor, is something that is nurtured
12 and enabled through a student educator, because that person
13 supports the student but also supports the breadth of
14 clinicians who are trying to provide a good quality
15 experience for students needing to meet their capability
16 requirements as part of their placement experience.

17
18 The other thing that makes it a bit tricky when we
19 start talking about transitioning into employment is,
20 unlike medicine and nursing and midwifery, allied health,
21 aside from a program that runs voluntarily with
22 physiotherapy, does not have any centralised recruitment
23 processes. There's no new grad statewide program. Years
24 and years and years ago there used to be new graduate
25 positions that were highly competitive and people really
26 wanted to work for us, and I'm pretty sure there are a lot
27 of people that want to work for us --

28
29 PROFESSOR NEWTON-JOHN: Absolutely.

30
31 MS DOMINISH: -- but the problem is we don't have
32 identifiable or consistent numbers of new graduate
33 positions where we can bring people in and so then that
34 makes it a bit tricky when you're trying to build
35 confidence in the student pipeline to come and work with us
36 straight from graduation.

37
38 MR MUSTON: Why is that? Why is it that there is a less
39 seamless path into a graduate recruitment type position for
40 allied health than, say, nursing? Medicine is a bit
41 different because you don't have any choice, but --

42
43 MS DOMINISH: I think comparing it to something like
44 medicine, where, for all medical graduates they have to do
45 an internship to get their registration, so historically,
46 by way of sort of forced requirement, they have had to do
47 that one year of internship to then get their registration,

1 and the perfect place for that to occur was always
2 NSW Health. That has expanded over time where there are
3 other private organisations that form part of the
4 allocation process, where people can do their internship.
5

6 I think scale with nursing and midwifery, again, you
7 are dealing with one discipline, or one other discipline,
8 and you've got large numbers. So in that hierarchy of care
9 you're always going to have room for that new grad level
10 and then you've got the more senior ones on top.
11

12 In allied health, you might have a district like
13 Western Sydney, you might have a large physiotherapy
14 department and you could probably identify two new grad
15 positions every year, but if you are out in back of Bourke
16 somewhere, you've got a more dispersed model across the
17 districts, and so where you might be able to allocate or
18 have a new grad position might vary depending on who else
19 is there and what type of work. So it is not that it can't
20 be done, I think it is just that it has never been properly
21 focused on with a centralised approach. I've used that
22 word. So, yes, I definitely think that there is an
23 opportunity to potentially consider it.
24

25 There also hasn't perhaps been a focus - I talked in
26 my statement about things like the medical cadetship
27 program that the Rural Doctors Network runs, and to go to
28 those examples you have provided previously about some of
29 our hard to fill positions, perhaps if there was new
30 graduate positions created in areas of need that did maybe
31 have a return of service component, that might be a good
32 way to go, but it would need to also come with what is the
33 scaffolding and support that you're providing those people,
34 particularly if they are going out, again, they will be
35 working in isolation so needing that sort of support or
36 transition to practise.
37

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

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

6
7 MR MUSTON: Taking it right back to the very start of the
8 pipeline, to the extent that the ministry has data
9 available at its disposal about areas of critical need -
10 and I think you mentioned earlier radiation therapists - is
11 there a conversation which happens between the ministry,
12 informed by that data, and education providers such as
13 UTS --

14
15 MS DOMINISH: Absolutely.

16
17 MR MUSTON: -- about standing up courses to produce more
18 radiation therapists, just as an example?

19
20 MS DOMINISH: Yes, absolutely. So this is one profession
21 that we're taking some pretty specific action on. So aside
22 from the usual conversations we have with the deans,
23 radiation therapy, just to put it in context, there used to
24 be a course run by Sydney University which closed, it might
25 have been about six or eight years ago now, so that
26 pipeline has stopped completely. So now we only have
27 University of Newcastle and Charles Sturt down in Wagga,
28 and then there's a masters program running out of Monash in
29 Melbourne.

30
31 MR MUSTON: Just pausing there, radiation therapy is
32 different to radiography.

33
34 MS DOMINISH: Correct.

35
36 MR MUSTON: It is not taking images using radiation but
37 it's rather administering radiation as a therapy.

38
39 MS DOMINISH: Yes. So radiation therapists operate the
40 big linear accelerators. If any of you have undergone
41 cancer treatment yourself or your family members, it
42 requires a complex planning process. The person will come
43 in and be positioned and have that treatment applied by a
44 radiation therapist. There's no replacement workforce and
45 we cannot run linear accelerators without radiation
46 therapists. So it's really critical for the viability of
47 timely access to cancer treatment for our population.

1
2 We don't have a metropolitan course anymore, and
3 that's a significant issue, and our biggest demand comes
4 out of Sydney and - Western Sydney, South West. So it is
5 an interesting situation because it's a bit of reverse
6 rural problem.

7
8 In order to tackle this, with support from the
9 secretary, we stood up a radiation therapy action workforce
10 group that's been running for almost six months now, and
11 that's in partnership with the current course providers as
12 well as radiation oncologists, our heads of radiation
13 therapy and ministry experts and our chief allied health
14 officer, to rapidly look at what are some immediate things
15 we could potentially do to try and boost the pipeline, as
16 well as attract and retain people into that profession.

17
18 Our future workforce unit, headed up by Tamara Lee,
19 held what we called the first of - we haven't done it
20 before - an accelerator, where we brought all stakeholders
21 together including the private sector and universities to
22 have a really intensive discussion to try and come up with
23 one potential solution or action that we could focus on to
24 try to, I suppose, unblock the pipeline in the short term.
25 So we're working through the recommendation of that right
26 now.

27
28 So, to your question, yes, we do, and the challenge
29 for radiation therapy is we've got a workforce that is now
30 extremely tired, they are working long hours. The private
31 sector snaps up people after they've been out a couple of
32 years and uses them, you know, obviously for services
33 there. We have to support them to take placements, but
34 then we've got this issue of there's no workforce to
35 back-fill the holes and so how do we get students in on
36 placement that we desperately need to employ when they are
37 graduating.

38
39 So we've sort of got the puzzle pieces. How do we
40 keep everyone afloat while we're trying to build that
41 pipeline? Certainly one recommendation has been absolutely
42 supporting the existing staff and the students with
43 dedicated facilitators and educators so the staff can keep
44 running the services and help with the placements.

45
46 Then the other opportunity we've looked at is the
47 current allied health award doesn't allow employment of

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

8
9 The new thing that has come into the market is the
10 course in Victoria, which is a two-year masters degree. So
11 to boost the pipeline we're going to need to try and target
12 people who have done things like science degrees or other
13 degrees and haven't really worked out what they want to do
14 but that might be really keen to become a radiation
15 therapist - so thinking outside of the box. And any other
16 suggestions that anyone has would be welcome.

17
18 MR MUSTON: Using that as an example, your institution,
19 UTS, does not currently offer a course in radiation
20 therapy.

21
22 PROFESSOR NEWTON-JOHN: No.

23
24 MR MUSTON: Has your institution been part of the
25 discussion around how to solve the radiation therapy
26 crisis?

27
28 PROFESSOR NEWTON-JOHN: Not radiation therapy, no. We've
29 actually looked at sonography and ultrasound as a potential
30 new course but not radiation therapy.

31
32 MR MUSTON: Using sonography as an example, did you end up
33 standing up a course in sonography?

34
35 PROFESSOR NEWTON-JOHN: We didn't, no.

36
37 MR MUSTON: Why not?

38
39 PROFESSOR NEWTON-JOHN: Primarily because of the number of
40 hours of supervised placement time that that accreditation
41 body requires means that students essentially need to be
42 employed three days a week in order to meet the number of
43 hours requisite for the qualification and the feeling
44 initially was that that would require such an industry
45 collaboration, in terms of that being a viable option, that
46 it wasn't something we were able to do straight up.

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

5
6 PROFESSOR NEWTON-JOHN: Indeed, and a very generous
7 employer to release that staff member for their two days
8 a week on their course whilst they're not performing in
9 the - you know, seeing patients as part of the organisation
10 they're working for.

11
12 MR MUSTON: In the allied health space, would it be right
13 to assume that the particular requirements in terms of that
14 practical component of the course would vary from one
15 discipline to another? So sonography sounds as though it
16 is one that has a high level of practical involvement,
17 whereas perhaps physiotherapy or occupational therapy might
18 not require quite the same amount of face-to-face.

19
20 PROFESSOR NEWTON-JOHN: Yes, they vary in terms of the
21 number of hours, in terms of the diversity of placement, in
22 terms of the qualifications of the supervisor, you know,
23 they all have their own sort of processes.

24
25 MR MUSTON: Having regard to the relatively thin market of
26 placements and potential candidates participating in those
27 placements across each of the different allied health
28 disciplines when compared with, say, nursing or medicine,
29 is there scope for a greater level of centralisation of
30 that allied health placement/practical education component
31 being delivered through the public health system? That is,
32 unlike the current arrangement which seems to be brokering
33 of a placement arrangement between a facility or an
34 individual clinician within a facility and an institution,
35 is there scope for all of those different allied health
36 professions to be grouped together under the banner of,
37 say, an adequately funded HETI to distribute those
38 placements - collect and distribute those placements in a
39 way that works for the system best?

40
41 MR GRIFFITHS: I think yes, and it is different to the
42 conversation we had this morning with nurses, because
43 I think there's probably greater need for centralisation
44 for allied health given the challenges we've just talked
45 about, the fractionated appointments, et cetera. Again, we
46 would be open to a conversation about it, but the same
47 thing as this morning applies for allied health. There are

1 arrangements with education providers and organisations
2 that would be challenged by us centrally dispersing or
3 distributing students across the system. So we would need
4 to work through that as a collective in order to be able to
5 do that at a more centralised level.
6

7 MR MUSTON: Can I just test that with you, and I will come
8 to you, Ms Dominish, in a minute, and perhaps,
9 Professor Anderson, tell me if you have a view on this, but
10 I understand the position that is being put is that there
11 are some longstanding arrangements between institutions and
12 particular LHDs or facilities around the placements with
13 students from one facility going to an institution. Is the
14 point that if you were to centralise it tomorrow and sever
15 all of those relationships and try and build a new
16 centralised process for distributing those placements, that
17 there would be a great disruption of a system which, whilst
18 not perfect, is at least providing a service, and that
19 perhaps what would be needed is a period of transition
20 where you moved into a central system which, in and of
21 itself, possibly took into account existing relationships,
22 many of which might be geographical and have other logical
23 bases which sit behind them? That was a very long
24 question.
25

26 PROFESSOR ANDERSON: I think for us, partnerships are key.
27 We don't have courses without partnerships with clinical
28 agency. We work in any and every way we can to try to get
29 the best clinical placements for the number of students
30 that we have across all of the health disciplines.
31

32 I would just say also that most of our allied health
33 are actually postgraduate courses, so, you know,
34 post-registration, so they all come in with a degree and
35 then they will do the various allied health, except for the
36 bachelor of psychology. So all of ours are in that way
37 anyway.
38

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

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

5
6 MR MUSTON: Ms Dominish?

7
8 MS DOMINISH: I think I'll just park the issue of the
9 allocating the placements for a second, but acknowledging
10 that there has already been commentary around if that was
11 occurring, it would need to be married with a recognition
12 of the required resourcing to support that to occur and in
13 a more transparent and equitable way across the state.

14
15 What has occurred in Queensland, which you may already
16 be aware of, was back in, I think, 2014 they had a huge
17 review of the clinical training landscape in response to
18 a number of incidents, and in the allied health space
19 through an enterprise bargaining agreement there was
20 a significant injection - I think 164 FTE - of educators
21 across the state to be able to immediately uplift clinical
22 placement capacity because they'd had a very significant
23 increase in the number of universities and courses that had
24 come on board in Queensland in a short period of time.

25
26 What they did, from my understanding, was they divvied
27 that up based on the scale and size of the allied health
28 workforce. For example, with physiotherapy, they had
29 a state level person that would provide guidance
30 consistency and leadership around clinical education for
31 physiotherapy with locally based student educators around
32 the state, so there was a bit of, like, a community of
33 practice and network but it was connected to a central
34 strategy and standard.

35
36 For the smaller professions like podiatry, I think,
37 child life therapy, et cetera, it was either fractional
38 appointments or people that were allocated regions, or if
39 they were really tiny, one person for the state. So in the
40 examples you were providing, say we needed a placement for
41 child life therapy, that might need to be something that is
42 done with a statewide view as opposed to the bigger
43 professions like physio that are well established, have
44 large departments and really close relationships with the
45 universities.

46
47 I think it is a difficult situation because the

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

5
6 MR MUSTON: Is a potential way of dealing with it which
7 quarantines some of the clinical educators from budgetary
8 pressures which might see them as being, in a very
9 challenging budgetary environment, the first to go,
10 providing a budget to, say, a central organisation like
11 HETI, charged hypothetically with the responsibility of
12 managing this placement scheme and coordinating centrally
13 with all of the universities about the placement, but
14 equally having within its budget this education component
15 or the clinical educator support component, to use your
16 example, very small specialisation, there might be only one
17 in the state; a bigger example that actually might need one
18 or more than one in each LHD, it comes down to HETI with
19 its budget - I say "HETI", but a HETI-like organisation -
20 to deliver to ensure that that support is funded and
21 provided, and also to do it in a way which is well
22 coordinated with the distribution of placements across the
23 system, managed centrally to make sure as many placements
24 as can be found in areas of need can be found and
25 coordinated with the universities who, of course, will have
26 their own push and pull factors around different
27 connections that they might have with different LHDs?

28
29 MS DOMINISH: Potentially, and I think some of the
30 evidence that has come out of the Queensland experience -
31 there are two papers and I'm happy to send them to you via
32 Crown solicitors - where they did a bit of a preliminary
33 evaluation of the efficacy of the model and its ability to
34 increase the placement capacity and then they re-looked at
35 that and published again in 2020 and it was shown that even
36 when they had challenges around staffing, they were able to
37 maintain that capacity through the investment in the
38 educators but also the statewide networked approach.
39 That's on the side of the student education perspective.

40
41 I think there would still need to be recognition of
42 the relationships and the role of the student educators in
43 those home bases and the connectivity to the clinical teams
44 and services and, you know, OT managers or whatever it is.
45 But I think that could have merit, yes.

46
47 MR MUSTON: Viewing this as yet half finished jigsaw from

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

7
8 PROFESSOR ANDERSON: I think a consideration of that role
9 in the model could be considered as part of the review,
10 and, you know, part of our central UTS recommendation was
11 a review of the clinical practice model if possible. So
12 I think that would be something that you would want to
13 consider.

14
15 MR MUSTON: So when you say "a review of the clinical
16 practice model", will they vary from the --

17
18 PROFESSOR ANDERSON: The clinical placement.

19
20 MR MUSTON: Oh, the process.

21
22 PROFESSOR ANDERSON: Sorry, yes.

23
24 MR MUSTON: Can I ask, perhaps starting with you,
25 Professor Newton-John, to maybe conceptualise what you see
26 would be a pathway for a student that might best place
27 a student in an area of allied health need in a situation
28 of perhaps a rural LHD or a rural facility, where that need
29 was greatest. Sort of talking through it from the
30 student's point of view are you able to conceptualise
31 a path - and Professor Anderson, jump in as well - that you
32 think would work in terms of funnelling that potential
33 workforce into the areas where it's needed?

34
35 PROFESSOR NEWTON-JOHN: So again I think to the point
36 I made earlier, a lot of newly qualified allied health
37 students are interested in working in health, and whether
38 it's rural or it's metropolitan, it's the fact of working
39 in a hospital and a hospital environment and the potential
40 benefits that can come from that, which we've talked about,
41 which is the attraction. So my sense is that the pathway
42 would be along the lines of ensuring that there was
43 adequate supervision, that they weren't left on their own
44 as a sole practitioner, newly qualified, managing all sorts
45 of complex cases with no-one to support them. So ensuring
46 that if it was a rural position, that there were at least
47 senior clinicians that they could be supported by.

1
2 I think it's mentioned too somewhere in the documents
3 here, whether there was financial incentive to assist them
4 with perhaps, you know, moving to a new location. A lot of
5 our students, although it's a graduate entry school, return
6 to live with their parents in order to do the training
7 because they can't afford to be working and studying full
8 time and being on placements for the protracted periods of
9 time that they can't work.

10
11 So for that sort of student cohort to move out of the
12 metropolitan area, if there was a financial support to do
13 that, I'm sure that would be very welcome. But a large
14 part of it, my sense is, is that they would not be kind
15 of - you know, that's a time where lots of supervision and
16 ongoing clinical professional development is critical, and
17 as long as those supports were in place, I think those
18 rural positions would be very attractive to a lot of
19 students, or new graduates.

20
21 MR MUSTON: In terms of placements at that early stage of
22 the pipeline, do you think placement scholarships and
23 perhaps even cadetships or indentured scholarships that
24 required a period of return service would work?

25
26 PROFESSOR NEWTON-JOHN: In terms of yes, whilst they are
27 still training, absolutely they would. Because at the
28 moment for our students if they want to do a placement in
29 Melbourne, we support them to do it or they support
30 themselves to do it, and not every student can do that, of
31 course. It's not equitable in any way at the moment, so if
32 there was an opportunity whilst they are training to do
33 a placement and be supported to do it remotely, they
34 would - you know, the feedback is they all want to do it.

35
36 MR MUSTON: Are cadetships and indentured scholarships
37 something that the ministry has looked at in terms of
38 dealing with areas of particular need within the allied
39 health workforce?

40
41 MR GRIFFITHS: Yes, and scholarships and stipends and
42 grants. We've got a range for allied health. The
43 challenge really is because there aren't enough students,
44 the metro is too attractive. So we've got a range - and we
45 advertise scholarships and cadetships and grants, and we
46 give them out, but for a lot of students, particularly in
47 the post-grad environment, it is hard if they're in a

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

6
7 MR MUSTON: And that contributes to the maldistribution,
8 in part because metropolitan might be seen as more
9 desirable, and in part because their training and
10 placements have, no doubt, been predominantly within the
11 metropolitan setting --

12
13 MR GRIFFITHS: Yes.

14
15 MR MUSTON: -- which tends to funnel them in that
16 direction, anyway

17
18 MR GRIFFITHS: Yes, and metro is short as well.

19
20 MS DOMINISH: Then we still have the issue that I referred
21 to earlier of the lack of new graduate appropriate roles
22 across NSW Health. So even if they want to, for example
23 work somewhere, there may not be a new graduate position
24 available at the right time there. So it might come up
25 in June or July, but they're already looking for a job
26 in January. So that timing - and that's where perhaps
27 a more considered approach around cadetships that are
28 paired with return of service, obviously still in line with
29 recruitment and selection policy - that's something we
30 haven't done but that would require obviously a financial
31 investment, but partnership and cooperation with the local
32 health districts that would see that as being of value.

33
34 MR MUSTON: This is a genuine question: would it really
35 require a significant financial contribution or investment
36 in circumstances where all that it would be doing,
37 theoretically, is filling a role that you might otherwise -
38 that is funded and you would otherwise be wanting to fill,
39 albeit doing so preemptively rather than after and perhaps
40 long after the vacancy has become available?

41
42 MR GRIFFITHS: But often the role isn't filled.

43
44 MR MUSTON: It's not filled?

45
46 MR GRIFFITHS: No.

47

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

10
11 MR GRIFFITHS: There is real opportunity, I think, and it
12 all comes down to finance. I have put in my statement that
13 there are approaches to workforce replenishment that have
14 been used in other areas of government and other
15 jurisdictions that have been really successful at targeting
16 areas of identified shortage, but it requires a significant
17 investment.

18
19 The one that I will refer to specifically is one ran
20 in SA Water for quite a while for engineering shortages,
21 where they effectively over-established. They filled
22 over-establishment a couple of years out from the time of
23 someone notifying that they were intending to retire, so
24 the exiting workforce would approach the organisation,
25 a grad would come in behind that person full time and
26 shadow them. So there are things like that --

27
28 THE COMMISSIONER: Did that work?

29
30 MR GRIFFITHS: It did. It has been very successful.

31
32 THE COMMISSIONER: It's an ongoing program there, is it?

33
34 MR GRIFFITHS: I'm not sure if they are running it now but
35 it was running at the time. There was a critical
36 engineering shortage.

37
38 THE COMMISSIONER: It achieved its purpose.

39
40 MR GRIFFITHS: Yes.

41
42 MR MUSTON: The investment is obviously you are, for
43 a time, paying two people to do the one job --

44
45 MR GRIFFITHS: Correct.

46
47 MR MUSTON: -- albeit one relatively junior person.

1
2 MR GRIFFITHS: That's right, for a defined period and
3 usually it was one or two years. But what it did was it
4 shored up supply for that area of shortage.

5
6 There is an opportunity in these sorts of areas for us
7 to explore that, but it all comes down to whether we've got
8 capacity within our budget.

9
10 MR MUSTON: Could that opportunity be combined with the
11 placements, though? Within the allied health space, say,
12 your two years worth of shadowing, if it were two years, at
13 least one of them, would it be possible for that to be
14 happening at a relatively cost neutral --

15
16 MR GRIFFITHS: The reason that I raise it in that context
17 was along those lines, that if you had that sort of
18 investment, that would then open up places where you know
19 that you've got some certainty for that student pipeline.
20 So you can run your student placements knowing that there
21 is going to be a vacancy as a result of that replenishment
22 strategy.

23
24 MR MUSTON: I used the term "cost neutral" earlier, and
25 I'm not wanting to discount the cost of the training
26 component, but a placement which was happening in
27 circumstances where the student was attending, observing,
28 being trained without being employed, would obviously
29 potentially give you some of that overlap, but there would
30 also possibly be some scope to employ someone as an
31 assistant in allied health, they could take that role
32 through that period whilst they're training, might assist
33 to cover the cost of being out in our Brewarrina situation,
34 and at the end of which may be indentured, maybe just
35 because that's the way the pipeline would be steering them,
36 the candidate ends up working in that area of need. That's
37 the theory?

38
39 MR GRIFFITHS: Yes.

40
41 MR MUSTON: From the perspective of someone who engages
42 regularly with students, do you see that,
43 Professor Newton-John, as being something potentially
44 desirable?

45
46 PROFESSOR NEWTON-JOHN: Yes, absolutely. For the students
47 who are interested in working in those areas, it would be

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

5
6 MR MUSTON: In terms of if there was the assistant in
7 allied health type employment as part of it - let's explore
8 in a minute whether that could be all of the placement,
9 whether it should be broken up into part employment and
10 part just pure observation - that presumably would assist
11 to cover some of the financial challenges associated with
12 placements in rural and remote areas?

13
14 PROFESSOR NEWTON-JOHN: We don't have assistant in allied
15 health positions. It's not a pathway that we have, but
16 I guess you guys are referring to employing a student in
17 that level position.

18
19 MR GRIFFITHS: That allied health assistant issue still is
20 challenged by metro versus rural sort of saturation. You
21 would want an assistant in allied health, for example, to
22 be working while they study, to get the most out of that
23 placement, but that's only going to be possible if they're
24 working in an area that's within a commutable distance from
25 their study, or we design a course so that there's a way of
26 that being excused from on-campus attendance and they can
27 relocate for a period in some of the other hospitals.

28
29 But again, it does come down to that issue of student
30 poverty. I mean, that's a way of overcoming it, but the
31 student placement thing is then limited by that as well.
32 It's an imposition for the student.

33
34 MR MUSTON: In terms of the university side of that, is
35 there, at least within your institution, a willingness or
36 an ability to be more flexible, perhaps, than historically
37 institutions have been about the way in which education in
38 an allied health discipline is delivered, say to facilitate
39 three months, six months placed in a rural hospital working
40 as an assistant in allied health doing some placement,
41 perhaps receiving some remote education and then - no doubt
42 you guys would go a lot better than me about how else it
43 could be done - you could perhaps have them coming back for
44 some residential components? Is that the sort of thing
45 that your institution is exploring?

46
47 PROFESSOR ANDERSON: Definitely. We have a lot of hybrid

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

15
16 MR GRIFFITHS: Can I just add, the other thing, in terms
17 of the assistant in allied health - and it won't so much be
18 for UTS because you've got post-grad entry, but for the
19 other universities where they have undergraduate entry,
20 there is no articulation from the certificate that they do
21 through the vocational training institutes for the allied
22 health assistants towards a degree. It would be really
23 helpful if we were able to influence - and I know that's
24 not necessarily just the university, that will also be the
25 councils and the accredited bodies, but I think that's
26 a big omission at the moment. We don't have that
27 articulated pathway to move from vocational education into
28 the undergraduate degrees.

29
30 If we could get that, I think there would be a lot
31 more - there would be more willingness for local health
32 districts to establish assistants in allied health, knowing
33 that it's leading to a pathway to a registered
34 professional.

35
36 MR MUSTON: Is that to be contrasted with nursing, where
37 I think, as we understand it, after a period of your
38 nursing sturdy, either through vocational training whilst
39 you're finishing your school, or alternatively through
40 a tertiary education when you finish your first year of
41 your registered nurse's degree or your nursing degree, you
42 then acquire a formal qualification as an assistant in
43 nursing. Have I understood that correctly?

44
45 PROFESSOR ANDERSON: Certainly with the programs that we
46 have with assistants in nursing who are doing it through
47 the bachelor of nursing with our local health districts,

1 no, that doesn't transfer. So it's not a replacement of
2 the clinical practice, which they still need to do, because
3 it is at a very different level. However, there are in
4 nursing, you know, the VOC ED through the enrolled nurse,
5 et cetera, that that goes through.
6

7 I think I read in here a thought about would there be,
8 like, an RN qualifying going through? I guess that idea
9 that you are talking about would probably work across the
10 health professionals, whether it was nursing or allied
11 health. It could be something that could really be an
12 opportunity, I think.
13

14 MR MUSTON: Am I right in my understanding that with
15 a bachelor's degree as part of this nursing program that
16 you've got where someone is employed as an assistant in
17 nursing after their first year of study, the employment as
18 an assistant in nursing is no substitute for the placement,
19 which is a different level of experience which requires
20 them to observe and participate in things which sit above
21 the ordinary duties of an assistant in nursing?
22

23 PROFESSOR ANDERSON: Correct.
24

25 MR MUSTON: But at the end of their first year of study
26 they do come away with a piece of paper which qualifies
27 them to be employed as an assistant in nursing; is that
28 right?
29

30 MR GRIFFITHS: It's not so much a piece of paper. That's
31 a policy decision from NSW Health that we have - we have
32 taken a decision that students at the second year can move
33 in and work as an assistant in nursing.
34

35 Through the vocational education pathway, though, you
36 can articulate all the way through. So you can start out
37 as an assistant in nursing, which will count towards your
38 enrolled nursing course, which will then count towards your
39 RN course. So you can keep studying without necessarily
40 starting from scratch every time.
41

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

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

8
9 MR MUSTON: Commissioner, I know you had some questions --

10
11 MS DOMINISH: Just to add to that, so I think where we're
12 coming from with this is so to be employed as an allied
13 health assistant you can walk in off the street and get
14 on-the-job training, or you can do your Cert III or
15 Cert IV. So I think the angle that has been coming from
16 here is say you have someone who is interested in allied
17 health, they do their Cert IV and they work as an allied
18 health assistant in a designated role that is a permanent
19 role or whatever that the system needs, and then they
20 decide, "Actually, I'd really like to be a podiatrist. Can
21 I use that Cert IV as RPL or entry to get into an
22 undergraduate degree as a podiatrist?" That's absolutely
23 something we're trying to look at for the Aboriginal
24 workforce, because we desperately need Aboriginal
25 podiatrists, as opposed to an undergraduate, already
26 studying, who is employed in an AHA role who we know is
27 hopefully going to graduate after that.

28
29 MR MUSTON: And if we could get the recruitment lined up
30 with the point at which they graduate, you would hope that
31 the chances of securing them as an employee of the public
32 health system might be improved. -

33
34 MR GRIFFITHS: No argument from us that we need to be into
35 the degree students earlier and offering jobs earlier.

36
37 MR MUSTON: I think, Commissioner, you said before lunch
38 that you had some questions --

39
40 THE COMMISSIONER: On a more general topic.

41
42 MR MUSTON: I'm just mindful of the time, I'm happy for
43 you to use the time now --

44
45 THE COMMISSIONER: Are you switching topics?

46
47 MR MUSTON: I was going to, yes.

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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

1 hospitalisation, so all that acute care stuff --

2

3 MR GRIFFITHS: Yes.

4

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

14

15 MR GRIFFITHS: Yes.

16

17 THE COMMISSIONER: So I'm not misunderstanding that?

18

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

20

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

22

23 THE COMMISSIONER: Of course, you can, yes.

24

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

33

34 MR GRIFFITHS: Yes.

35

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

45

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

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

10
11 They are the things that at the moment we do some
12 thinking about but we don't bring them about enough,
13 because we're locked in to the workforce and the workforce
14 profiles that we've got. So a lot of our workforce
15 profiles are retrofitted into: well, we've got this many
16 doctors, the doctors can work to this scope, or the nurses
17 can work to this scope, and so we create a service profile
18 that allows us to provide that service, but it may not be
19 the ideal make-up. So that's what I'm getting at with
20 that.

21
22 Then if you knew what the missing category or
23 classification was, then you would do the next overlay,
24 which is, well, how many of them do we need and at what
25 point? Like, where do the existing workforces complement
26 the skill that would be required with that workforce?

27
28 THE COMMISSIONER: Looking at that big picture area of the
29 workforce that might be needed to achieve desirable
30 outcomes, one just being improve population health, and,
31 two, I guess we don't know, but let's hope that might cause
32 a decrease in the growth of the costs of providing
33 healthcare services, public healthcare services.
34 NSW Health or any health department can't do that on its
35 own, though; it's related to other activities and
36 departments of government, for example, housing, education,
37 all of those things need to be linked together to achieve
38 those more desirable outcomes that we've just been talking
39 about in terms of population health and maybe reduced
40 healthcare costs.

41
42 MR GRIFFITHS: That's right. All of those things you've
43 mentioned there are determinants of health. Even to bring
44 about any sort of change, the other stakeholders like my
45 colleagues at the table here, they have to be in the
46 conversation as well because we have to be redesigning.
47

1 THE COMMISSIONER: Yes. Okay.

2

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

9

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

17

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

27

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

33

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

37

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

1
2 But I think there is an absolutely willingness on the
3 university side to be as flexible and as accommodating and
4 as innovative as we can be, bearing in mind I think the
5 other thing we need to recognise is there are accreditation
6 bodies sitting across all of these disciplines which have
7 some influence over how we train and to the extent that we
8 train, but that notwithstanding, there is an absolute
9 imperative for all of us to find solutions. So I think
10 that's a pretty good starting point.

11
12 MR MUSTON: In relation to that, particularly in some of
13 the rural and more remote areas we've heard about the
14 fractional appointments of allied health professionals and
15 the challenges that that raises in terms of placements and
16 placement supervision. Is there scope for a collaboration
17 between educational institutions, the public health system
18 and private providers to deliver a placement experience
19 which utilises both public and the private system in a way
20 that maximises the experience for the student but equally
21 increases the possibility that a student who might be doing
22 part of that placement through the public health system,
23 albeit supervised perhaps remotely or by a private
24 practitioner in a town, is incentivised to move into the
25 public health system when they get their graduate job or
26 are looking for their graduate job?

27
28 PROFESSOR NEWTON-JOHN: Certainly from the university side
29 there is and, in fact, we do do this sometimes. As we
30 said, there's such a shortage, sometimes it is stitching
31 together some hours here and some days there. But yes, you
32 know, as long as the student is getting the appropriate
33 level of supervision, where it's coming from, sometimes
34 that diversity is a great thing for the student experience.
35 So certainly from our side, yes.

36
37 MR MUSTON: Accepting that having people stitched together
38 in the NDIS sector, for example, in a way might be pushing
39 them away from the public system unless you can nimbly
40 snatch them up as graduates, is there a process within the
41 ministry for helping facilitate this stitching-together
42 process or is that part of the work to be done?

43
44 MR GRIFFITHS: Probably part of the work that needs to be
45 done. Given the fact that there is a bit of a disparity in
46 terms of pay rates in the private sector versus the public
47 sector with a lot of the allied health disciplines, I would

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

4
5 MR MUSTON: When you say "NGOs", do you have in mind --

6
7 MR GRIFFITHS: Non government organisations, some of which
8 we fund.

9
10 MR MUSTON: -- organisations like Marathon Health, for
11 example?

12
13 MR GRIFFITHS: Sorry?

14
15 MR MUSTON: Organisations like Marathon Health, for
16 example?

17
18 MS DOMINISH: They are an NDIS provider but they also do,
19 I think, some funded work through the government.

20
21 MR GRIFFITHS: I'm probably thinking more of some of the
22 organisations who work off government funding in the
23 non-government sector, though, so some of the mental health
24 providers, where there are some cost imperatives with them,
25 so we would probably be more of an attractive partnership,
26 I would think, rather than the private organisations.

27
28 We would be willing to really look at all of those
29 sectors, though, and I said this morning that it is
30 important that private hospitals come to the table with
31 some of this. The thing with allied health, the difference
32 with allied health, is that some of the private partners
33 aren't hospitals, they're private businesses who pay
34 significantly more than what we are able to pay.

35
36 MS DOMINISH: I think for it to be a success it would be
37 very dependent on the local relationships in that location,
38 and I know there are some districts that do that really
39 well, and the way that that district works with those
40 providers in general, I think that would be critical for
41 the success of the arrangement and the experience of the
42 student, because you could end up in a situation where it's
43 not a pleasant experience.

44
45 MR MUSTON: Does that suggest that to the extent that that
46 work is done, it's perhaps work that, whilst perhaps
47 facilitated from the centre, would be better executed in a

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

3
4 MS DOMINISH: I think so. I think you could set some
5 rules or standards or guidelines, but the actual putting
6 that together would rely on the local relationships,
7 agreement with the CEs in the universities and the relevant
8 other chief executives or leads of whatever those other
9 organisations were.

10
11 MR MUSTON: Commissioner, I have no further questions for
12 these witnesses, unless there is anything that any of you
13 think that we haven't covered

14
15 PROFESSOR ANDERSON: I would just say also that we have
16 clinics, university clinics, in speech and in psychology,
17 so they're also are good opportunities for the student
18 experience. We have some really great relationships with
19 local health districts and that has been a really great
20 positive. I think that we've been sort of managing like
21 that in different local health districts and I think that's
22 a certain way that we've been working.

23
24 MR MUSTON: Are the clinics delivered in the metro setting
25 or are they delivered through rural and remote LHDs as
26 well?

27
28 PROFESSOR ANDERSON: We've got both. We've got on campus
29 and we've got telehealth clinics that are being delivered
30 through exercise physiologists. I think one of the things
31 we haven't talked about is the opportunity for digital
32 health in rural and remote and being able to supervise
33 students digitally. They really do need to understand
34 telehealth now, which is a big component of many allied
35 health areas, so that's a piece of the pie that I think we
36 will put in as well.

37
38 MS DOMINISH: I just wanted to add to the commentary of
39 the Commissioner with Richard around looking at new
40 workforce models. I have provided a lot of evidence in my
41 statements around the different models that we're currently
42 working on, both for allied health but also paramedicine
43 and Aboriginal health practitioners, and I think - I won't
44 rehash it, but there was quite a lot of evidence provided
45 by Jill Wong, who is the director of allied health up at
46 Mid North Coast, around the tension between, like, yes, we
47 are responsible for a lot of the acute services, but if we

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

17

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

20

21 MS DOMINISH: Sure.

22

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

37

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

41

42 THE COMMISSIONER: Which may not be consistent.

43

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

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

8
9 THE COMMISSIONER: All right. Thank you. Is there
10 anything out of that?

11
12 MR MUSTON: No.

13
14 THE COMMISSIONER: Mr Cheney, I forgot to ask you whether
15 you wanted to ask any questions of the two prior witnesses.
16 I assume the answer is "No", because you didn't jump up,
17 but would you like to ask anything of these witnesses?

18
19 MR CHENEY: No, thanks, Commissioner.

20
21 THE COMMISSIONER: Thanks. That's it? All right.

22
23 To all four of you, thank you so much for your time. We're
24 very grateful, and also for the work that went into your
25 statements, too, which are very helpful. Thank you for
26 that, and to those assisting you.

27
28 **<THE WITNESSES WITHDREW**

29
30 THE COMMISSIONER: Do we adjourn until 2 o'clock tomorrow?

31
32 MR MUSTON: Yes.

33
34 THE COMMISSIONER: All right. We will adjourn until
35 2 o'clock tomorrow.

36
37 **AT 3.36PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED**
38 **TO TUESDAY, 15 OCTOBER 2024 AT 2PM**

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