NSW Special Commission of Inquiry into Healthcare Funding – Final report summary for ANZCA purposes

5 June 2025

Context

The Special Commission of Inquiry into Healthcare Funding, led by The Honourable Justice Richard Beasley, conducted a major review of the NSW public healthcare system and how it is funded.

After 20 months the Inquiry's final report was released on 16 May 2025. This is the most comprehensive review of the NSW health system in over a decade.

The report includes 41 recommendations across 12 key areas (totalling 1062 pages).

As part of the inquiry's work, ANZCA provided a submission to the Inquiry (one of over 200 stakeholders) and contributed to multiple targeted information discovery meetings, detailed witness statement preparation and hearing attendances.

The report recognises there is a shortfall in anaesthesia specialists compared with available positions in NSW, which is generally accepted in the NSW health community. The report also notes that while there are challenges in specialist training networks and hospital accreditation processes it singles out ANZCA for creating an "innovative model" of accreditation with a system of "satellite facilities that are not accredited themselves but operate under another facility's accreditation to deliver particular training requirements."

The Inquiry provided a small number of organisations who contributed to the Inquiry (inclusive of ANZCA), a copy of the draft findings in late 2024, requesting feedback. ANZCA provided this response – stating the recommendations are largely at a system level (necessary to cover the wide scope of the Inquiry) however the college was hopeful that the report would contain greater tangible or concrete recommendations which can be directly implemented, without any need for interpretation or the ability to backtrack or not implement.

ANZCA has also published a media release in relation to the report's release.

Over the coming months the NSW Government will provide a response to these findings.

A summary of the final report is provided below from the perspective of ANZCA's remit.

Findings

General summary

Many stakeholders have welcomed many of the findings, however there are concerns that the report falls short in addressing the scale and urgency of the workforce crisis facing the NSW public healthcare system. One of the central items was the urgent need for award reform to address outdated and unfair employment conditions. Although the report proposes an industrial relations commission (IRC)-led award reform process and acknowledges that NSW pays medical staff less than any other state or territory, the report includes no recommendation on remuneration or employment conditions.

Interestingly, the NSW Health Secretary's messaging regarding the release of the report focuses on the strengths of the NSW Health system, with excerpts of the report that reflect this, rather than the significant challenges the system is facing and the improvements that are required.

Notable clauses (ANZCA relevance)

Clause #	Description	ANZCA area of relevance
1.141	**HETI should also play a greater role in overseeing** a graduate recruitment program that focuses on recruitment of those who have held placements into areas of need upon graduation, and **the establishment and delivery of specialist medical training networks, prioritising those groups with projected shortfalls in training numbers**	Student placements

Clause #	Description	ANZCA area of relevance
	or serious maldistribution challenges. **Again, this will need to be done in collaboration with relevant medical colleges**, other training providers, and local organisations and in a manner which delivers on the objectives of the wider health service and workforce planning exercise I have described elsewhere in this Report.	
2.9	There are **parts of the health workforce who are suffering from "burnout".** At the time of writing, parts of the health workforce are engaged in industrial disputes with the State Government. **Outdated awards, a decade long public sector "wage-cap", and a lack of parity with pay available in other states have all contributed in varying degrees to that situation.**	Industrial actions
2.103-2.104	The current approach to **public health service and workforce planning in NSW is not built upon a comprehensive understanding of population health needs from the bottom up.** The **widespread disinvestment in planning resources within NSW Health and dissolution of its service planning branches, as well as underinvestment in retaining planning skill at the LHD level, has fostered a "patchy" approach to service and workforce planning**.	Lack of workforce and service planning
2.105 and 16.44	In particular, **NSW has not "done a very good job of predicting ahead of time how many doctors [it will] need, [and] how many nurses [it will] need"**, nor facilitating collaboration between educational institutions and medical colleges for the delivery of that workforce.	Lack of workforce forecasting and pipeline
16.45	This, at least in part, reflects the fact that that under the current framework there is **insufficient coordination of the many entities with input into, and influence over, the potential planning approach and its outcomes**, including the Commonwealth and State Governments, administrators of training placements, medical specialty colleges, and universities.	Insufficient coordination
2.107	The **absence of strong systematic planning has fostered the development of services in response to other drivers, such as funding and workforce availability, political considerations, and historical service commitments**. This method of growth has been **ineffective in promoting patient safety and fiscal responsibility**, and has culminated in a public health system that is increasingly being stretched unsustainably in an attempt to deliver as many services, in as many locations, as possible.	Funding and workforce availability, political considerations, and historical service commitments driving planning
2.122	**Most of the awards and other instruments setting the terms and conditions of employment or engagement for NSW Health workers do not reflect contemporary work practices**. **They have not been reviewed substantively for many years.** Many terms of those awards date back decades. There was general consensus (except in relation to the *Public Health System Nurses' and Midwives' (State) Award)* that NSW Health awards are outdated and no longer fit for purpose. … **There is an urgent need for a broad project of award reform in respect of NSW Health awards.** Recent history suggests that, if that does not occur, NSW Health, and the industrial organisations and their members, will likely continue to be engaged in a rolling series of negotiations and disputes. Indeed at the time of writing this Report, and throughout the duration of this Special Commission, negotiations and disputes have been ongoing.	Outdated employer terms and conditions
2.124	There presently exists a **disparity in the rate of pay between NSW and other Australian jurisdictions** for some of the health workforce. That disparity was cited as	Lack of parity of rates of pay with

Clause #	Description	ANZCA area of relevance
	being a factor in some of the **difficulties experienced in recruiting and retaining a permanent workforce, particularly in some specialties** and regions.	other states and territories
2.128	There have also been shortages of specialists to fill available positions in psychiatry, emergency medicine, radiology, and anaesthesia, as well as general practice.	Anaesthesia shortages
2.134	Currently, there is no system wide approach to workforce planning, in the sense that the **clinical workforce is not established or structured by reference to a detailed assessment of population needs or the supply of clinicians across the system**. The need for a system wide approach to workforce planning and engagement has increased in recent times as the effects of "pressure" on the health budget, and workforce shortages and maldistribution have become more acute.	System wide approach to workforce planning
2.142	As part of a **system wide approach to workforce planning, there should be greater strategic coordination and planning related to clinical placements and vocational training.** HETI is well placed to take a leading role in that process, and to perform that function going forward.	System wide clinical placement planning
2.151	There are high levels of fatigue, stress and "burnout" across the NSW Health workforce.	Staff fatigue and burnout
18.4	A significant issue that emerged in the evidence was that most of the awards and other instruments setting the **terms and conditions of employment or engagement for NSW Health workers do not reflect contemporary work practices.** Relatedly, there presently exists a disparity in the rate of pay between NSW and other Australian jurisdictions for some of the health workforce. That disparity was also cited as being a factor in some of the difficulties experienced in recruiting and retaining a permanent workforce, particularly in some specialties and regions.	Employment terms and conditions lack parity with other states and territories and aren't contemporary
18.9	Finally, training pathways – which fill and direct the health workforce pipeline – are poorly coordinated and have been left largely under the control of a wide range of different organisations, which are often unaware of particular workforce needs (in terms of both volume and distribution). **Such organisations (including, universities and specialist medical colleges) also have a very limited ability to harness or direct the resources needed to ensure reliable training pathways, with the consequence that training opportunities are concentrated in areas where these resources are plentiful and easy to corral, making them very metrocentric**. This has significant influence on the ultimate distribution of the workforce generated by these pathways and thereby contributes to maldistribution.	Lack of ability to inform and direct the training pathways
18.72	One concern that has been raised about the accreditation of specialist training is that colleges' accreditation decisions might occasionally have been influenced by industrial considerations. Although the evidence before this Special Commission does not indicate that such an approach is widespread, **some colleges acknowledged accreditation could be used as a "lever" to achieve certain outcomes desired by the college.**	Accreditation levers
18.73	Different arrangements apply between the colleges as to whether they are involved in the recruitment and selection of trainees or whether these processes were left to local organisations. Those **colleges that are involved in recruitment and selection considered this to be valuable because it allowed them to bring their Fellows' expertise to bear on those processes and allows for a more efficient process for interviewees.**	College involvement in the recruitment and selection of trainees
18.74	However, apart from influencing the maximum number of trainees who may be engaged at a given site and their training conditions, **colleges have a limited capacity to influence the number and distribution of trainees in NSW. They do not determine the number or distribution of trainee positions:** the establishment of a position is a	Colleges limited capacity to influence trainee numbers

Clause #	Description	ANZCA area of relevance
	discrete and additional step to the college's accreditation of sites or positions in which training is delivered. While most colleges have, to varying degrees, implemented initiatives aimed at increasing rural training (including through Commonwealth Specialist Training Program and Flexible Approach to Training in Expanded Settings funding), **all of the college representatives who gave evidence expressed a view that their colleges had no or inadequate access to data about service demands and workforce planning needs, which constrained their ability to contribute meaningfully to solving shortage and distribution problems.**	
18.87	there are inconsistencies in the approach to data sharing that occurs with other stakeholders including universities, specialist medical colleges and industrial organisations. Finally, in contrast to the data sharing that occurs between the Ministry of Health and local organisations, **there are inconsistencies in the approach to data sharing that occurs with other stakeholders including universities, specialist medical colleges and industrial organisations**. Stakeholders have access to publicly available data sources, including data made available by NSW Health through the Bureau of Health Information, and some high level workforce modelling outputs published on NSW Health's website. But **aside from those modelling outputs, this data is not typically collated, correlated or otherwise analysed as the Ministry of Health does. That must change.**	Data sharing with stakeholders
18.93	It is essential that the Ministry of Health has a key role in that process given that it, and it alone, has oversight over large amounts of workforce data and the ability to analyse and interpret that data at a system level. **It also effectively controls the funding allocated to local organisations to fund their workforce needs**. Those two matters alone make clear that the Ministry of Health must play a lead role in system wide planning of this kind if it is to be effective.	Ability to dictate funding allocations based on data control
18.126	The **existing networks relate to a limited number of specialties. The main (and perhaps only) reason for this appears to be a lack of funding to expand them**. In this respect, Dr Josephine Burnand, Acting Medical Director, HETI, gave evidence that: *There's certainly an opportunity to expand not only that work within the existing vocational training pathways that we currently oversight, but potentially additional specialist training pathways, particularly when there are workforce issues. And not only where there are workforce issues, but also potentially where there are issues of trainees along that pathway meeting particular training requirements … some of those bottlenecks that occur in order to meet the college requirements for the training.*	Lack of funding to expand networks
18.127	**The existing training networks have a "metropolitan centric" focus. This is partly symptomatic of a broader metrocentric approach to accreditation and training, which has seen the bulk of training concentrated in metropolitan areas.** But it is also a discrete network problem. For example, the Central Coast LHD considers that it has minimal influence over the allocation of specialist trainees within networks because this allocation is centralised and conducted in a metrocentric way. This is consistent with the perception by at least some college representatives that HETI (along with other parts of the wider system) is metropolitan focussed.	Metropolitan centric focus of training networks
18.129	There are, of course, challenges in any expansion of the vocational training networks and its related functions to address these deficiencies. These include: a) the need to accommodate each college's accreditation requirements. This will require the Ministry of Health, HETI and the colleges to work together to develop mutually acceptable solutions. There may be innovative ways of doing this. For example, the Australian and New Zealand College of Anaesthetists has a system of "satellite" facilities that are not accredited themselves but operate under another facility's accreditation to deliver particular training requirements. Several colleges are also increasing flexibility in supervision requirements by allowing for some	Training networks

Clause #	Description	ANZCA area of relevance
	volume of remote, virtual supervision; Standardisation of some accreditation requirements with the colleges should also be explored; b) the need to provide sufficient "protected time" for supervisors to enable them to deliver training effectively. This is a general problem but may be particularly acute in rural or remote facilities; c) the need to have appropriate structural supports in place for trainees required to live and work away from home for some or all of their training programs, including accommodation and social supports; d) the need for adequate funding for the development of new training networks, including for network director and educator roles, and for the enhanced coordinating role in terms of workforce planning. This will probably require some "centralised, quarantined funding" otherwise there is a real risk that through notional "efficiency" measures, positions such as those will not be retained; and e) e. the need to keep in mind colleges' national/binational jurisdictions, and trying to minimise "change fatigue" for colleges that have gone through other recent reviews impacting on their operations.	
18.130	As is obvious, pursuing that change will necessarily involve a **collaboration with the specialist medical colleges.**	Collaboration with the specialist medical colleges
18.131	However, none of these challenges is an insurmountable obstacle to expanding HETI's role in relation to training networks. At least some will be addressed through collaboration with the specialist colleges and local organisations, and the **continued use of the colleges' specialist expertise including in the governance and planning of those networks (which should include appropriate data sharing).**	College involvement in governance and planning of networks

Recommendations

The Inquiry's 41 recommendations are identified below, by relevant report/chapter area.

The health of the population and the need for prevention (chapter 10)
1. Preventive health should be made, and remain over the long term, a standing whole of NSW Government priority. (This measure should be implemented within 12 months of the date of the Report.)
2. The criteria against which all new NSW Government initiatives (including new policy proposals) are to be assessed should include a consideration of how that initiative will support the promotion and maintenance of the health and wellbeing of the population. (This measure should be implemented within 12 months of the date of the Report.)
3. All decisions made in relation to whether a new initiative or policy proposal is to be implemented should be informed by advice from a multiagency, multidisciplinary body led by NSW Health under the oversight of the Chief Health Officer, as to their potential impact on the health and wellbeing of the population, with a view to maximising the long term health benefits achieved through such decisions and insulating them, to the best extent possible, from the vagaries of the political cycle. (This measure should be implemented within 12 months of the date of the Report.)
Primary care and aged care (chapter 11)
4. In communities where there is an absence of effective and accessible primary care, NSW Health should, via the relevant LHD (and as an integral part of its service planning exercise), assess the nature and extent of the unmet primary care need and collaborate with other stakeholders to deliver adequate primary care. In many cases, this will require NSW Health to deliver that care or support its delivery. Access to Commonwealth funding streams for the delivery of this care should clearly be pursued by the NSW Government, but the delivery of primary care in

communities where it is lacking and determined by health planners to be a priority should not await the outcome of those intergovernmental discussions.
5. Where an inability to access appropriate aged care is having a direct and adverse impact on the delivery of acute care through public hospitals, NSW Health should, via the relevant LHD, and in consultation with the community and other stakeholders, conduct an assessment of the unmet aged care needs in the relevant community and coordinate with other stakeholders to support or deliver the required aged care services. Commonwealth funding streams for the delivery of this care should be pursued by the NSW Government, but the provision of aged care to the extent required to relieve the existing and unsustainable burden on public hospitals should not await the outcome of those intergovernmental discussions.
6. As part of the system wide planning process which is the subject of Recommendations 21-26, NSW Health should facilitate more regional training opportunities for primary care clinicians, and provide the training and support required for those contributing to the delivery of primary care to harness their full range of skills, including by working to the top of their scope of practice wherever clinically appropriate.
First Nations healthcare (chapter 12)
7. The planning of services for First Nations people must be a collaborative effort and involve all relevant stakeholders; with a particular focus on identifying and addressing service need and gaps, reducing duplication across providers to ensure an efficient deployment of available resources, ensuring the delivery of culturally safe care, and prioritising continuity of care. This must involve ongoing joint clinical service planning between NSW Health and ACCHOs/AMSs.
8. Wherever possible: a) yearly and other short term funding cycles for programs to be delivered by ACCHOs and AMS (particularly in relation to core, ongoing services) should be avoided; b) arrangements to pool resources for First Nations healthcare from the Commonwealth and the State that would support the efficient delivery of care to First Nations communities should be prioritised; and c) ACCHOs and AMS should be given flexibility, within the construct of the joint clinical service planning process, to use funding allocated to them to design and deliver the services required to meet the needs of the communities they serve.
9. Reporting requirements that attach to funding allocated to ACCHOs and AMS must be rationalised and simplified.
10. There should be greater collaboration and coordination with First Nations organisations across the State with a view to building a strong First Nations health workforce, and to optimise training pathways and workplace opportunities including in roles that are shared between, for example, ACCHOs or AMS and NSW Health agencies or facilities.
Statewide services (chapter 13)
11. The functional governance and accountability structures, service planning function, and funding responsibility for all Statewide Services (i.e., highly complex, low volume, services delivered across the State, whether designated supra-LHD services or not) should sit within the Ministry of Health.
12. The system wide service planning process which is the subject of Recommendations 21-26 should incorporate a Statewide plan for paediatric services that articulates the roles of the Sydney Children's Hospital Network, John Hunter Children's Hospital and the paediatric services delivered within LHDs. That plan should clearly identify the role of those specialist tertiary and quaternary centres in providing care and supporting the paediatric care that can and should be delivered in LHDs, or the primary care setting, and articulate care pathways for the movement of patients between those settings.
13. Justice Health (supported, as appropriate by other NSW Health agencies) should set the minimum nutritional requirements for the custodial population, that must be followed by those responsible for the operation of custodial facilities across the State. To the extent that Justice Health requires additional funding to perform that function, it should be provided. Any necessary amendment to s 236A of the Crimes (Administration of Sentences Act) 1999 (NSW) – or any other legislative provision – to give effect to this recommendation should be made within 6 months of the date of this Report.

14. There should be an independent review undertaken by an appropriately qualified person of:
    a) the current arrangements for access to psychological care in custodial settings; and
    b) the role of Justice Health in the delivery of care to forensic mental health patients through facilities across the State with a view to facilitating patient flow through that system.

Affiliated Health Organisations (chapter 14)

15. Each AHO should enter into a single service agreement with the Health Secretary – in much the same way as is currently contemplated for networked AHOs – and negotiations with those organisations regarding funding and the nature and location of services to be delivered under those agreements should principally occur at Ministry of Health level.

16. On an annual basis, and in conjunction with the planning and identification of the services to be provided by each AHO under their respective service agreements, Schedule 3 to the Health Services Act should be reviewed to ensure that it accurately records the recognised services and establishments contemplated by those service agreements and amended to the extent necessary to reflect those services.

17. A structured process should be implemented to promptly resolve any dispute between the Health Secretary (in her capacity as the counterparty to their respective service agreements) and an AHO regarding the extent to which funding offered is sufficient to meet the cost of delivering the level of service required under a proposed service agreement. Whatever process might be adopted, it must be independent, able to be unilaterally triggered by either the AHO or the Ministry of Health in the event of a dispute, and capable of meaningfully regulating the "purchaser / provider" nature of the relationship to be reflected in any subsequent service agreement. The outcome of that process cannot bind either the AHO or the Minister to enter into a service agreement on any particular terms.

Single Digital Patient Record (chapter 15)

18. The SDPR project should immediately be expanded to include facilities and services delivered by AHOs as part of the public health system and each AHO should be adequately funded by NSW Health to implement the SDPR within its operations.

19. NSW Health should collaborate with the Commonwealth Government and relevant technology platform providers to facilitate the expansion of the SDPR project to ensure that relevant electronic records generated in public hospitals are accessible to General Practitioners, specialists, allied health professionals, and community health clinicians delivering care outside the NSW public health system and, wherever possible, records created by such clinicians are able to be viewed by those providing care as part of the NSW public health system.

20. The NSW Government and NSW Health should urgently initiate discussions with the Commonwealth and their interstate counterparts (if they have not yet done so) with a view to achieving data uniformity and sharing across all public health systems in Australia.

The planning and delivery of health services in NSW (chapter 16)

21. NSW Health must implement a transparent, committed, and collaborative approach to system wide service planning that is coordinated and overseen by the Ministry of Health.

22. That system wide service planning process must involve at least:
    a) a substantive and detailed identification of
        i. the health needs of the relevant community. This must be done in genuine collaboration with the community, including other providers of healthcare within the relevant place;
        ii. those other entities, including other LHDs and providers outside of the NSW public health system, that are already (or are capable of) delivering services to meet the identified needs;
        iii. any service gaps, or other areas of need within the community that are not currently being met by available services;
        iv. which of those gaps the public health system should fill and how, both generally and within the relevant community. Once again, this is something that must be done in an open collaboration with the community, clinicians and all other providers of healthcare within the relevant place;

b) a system wide approach, coordinated within the Ministry of Health, to determining what services are to be provided through the NSW public health system to ensure that the identified health needs of the relevant population are met in an accessible but sustainable way, recognising that not all services can or should be provided everywhere;

c) ongoing and genuine collaboration with the community and other providers of health services to:

i. determine how emerging service gaps, and areas of need, are to be addressed

ii. identify all available funding streams, for example through collaborative commissioning models and the like;

iii. generate an evolving strategy which is forward looking and covers short, medium and long term planning horizons; and

iv. incorporate a genuinely collaborative and transparent processes of monitoring, to ensure the plan is delivering on its intended objectives and enables adjustment to be made where required.

23. Capital planning (i.e., planning for new facilities or significant upgrades to existing facilities) must be an integral part of that system wide service planning process and be aligned to its objectives. Decisions to construct new, or make significant upgrades to existing, facilities must reflect an assessment of the health needs of the population, and the most efficient and effective way of meeting them.

24. System wide, coordinated planning of that kind needs to be accompanied by a transparent articulation of the planning process, the health needs of the community identified through that process, the way in which those health needs are to be met and, to the extent that they are not, this also needs to be clearly articulated and an explanation provided of the rationale for this decision. It is essential that the extent to which those objectives are being achieved is reported upon in a frank and transparent way, supported by expanded reporting by the Bureau of Health Information.

25. The current suite of key performance indicators in Service Agreements and statements of service should be reviewed with a view to reducing the total number and improving the balance between the five types of indicators – input, output, outcome, lead and lag indicators. They should also be adapted to more meaningfully assess the extent to which each individual LHD or SHN is achieving the outcomes of its service planning and fulfilling its core function – including to protect, promote and maintain the health of the population. The development of such key performance indicators for each LHD and SHN should form part of the systemwide service planning exercise, and be tailored to the particular outcomes that are to be achieved by each of them.

The health workforce (chapter 14)

26. As part of the system wide approach to service planning, NSW Health should:

a) establish a central workforce planning function, located within the Ministry of Health, which collaborates regularly and systematically with local organisations to direct the clinical workforce establishment across the NSW health system with the objective of guiding the deployment of the human resources available within the system in a way that best meets the needs of the NSW population as a whole; and

b) once that function is established, prioritise a thorough, evidence based, review of specific initiatives that should be implemented to help address current workforce shortages and maldistributions

27. The Health Education and Training Institute's role should be expanded, with appropriate funding, to include:

a) coordinating the allocation of students to clinical placements within NSW Health facilities and services in collaboration with universities and relevant NSW Health agencies;

b) devising and overseeing a graduate recruitment program that capitalises on the clinical placements offered within the public health system and facilitates the early recruitment of those who have held such placements immediately upon graduation and into areas of need; and

c) establishing and delivering specialist medical training networks for all medical specialties, prioritising those with projected shortfalls in trainee numbers compared with service and workforce demands, in collaboration with the relevant medical colleges and local organisations, with the objective of matching the number and locations of placements and training positions with areas of future service and workforce need, and focussing upon maximising opportunities for training and recruitment in rural and regional locations.

28. There should be an award reform process conducted by the Industrial Relations Commission of New South Wales incorporating at least the following features:

a) a legislated set of objectives to be achieved by the process, which include:

i. simplifying and, where appropriate, consolidating the current range of awards, determinations and other instruments setting terms and conditions of employment or engagement for NSW Health workers, to provide a consistent and coherent framework of terms and conditions that is easy to understand and apply; and
ii. updating instruments so that they reflect the current and expected future service delivery and workforce needs of the NSW health system and current and expected future working conditions; and
iii. providing fair and reasonable terms and conditions of employment or engagement for workers across the NSW health system, including having regard to the value of their work to system, the impact of those terms and conditions on attraction and retention, and their fiscal and economic impacts;

b) a reasonable but expeditious timeframe in which the process is to be completed; and
c) an extension of the process to Visiting Medical Officers and the Visiting Medical Officer Determinations.

29. To the extent that legislative amendment is necessary for the Industrial Relations Commission of New South Wales to be able to complete the award modernisation process contemplated by Recommendation 28 other than in the context of an industrial dispute (and unconstrained any prior construction given to s 19 of the Industrial Relations Act), that amendment should be made urgently.

30. The Model By-Laws made under ss 39 and 60 of the Health Services Act should be reviewed and amended with a view to clearly identifying the role and functions each Council and committee established by them and ensuring that they:
    a) provide an effective and robust forum for consultation and feedback between clinicians and management; and
    b) are complementary of each other.

31. Steps should be taken to enhance collaboration between boards, executive management and clinicians, in addition to the review and amendment of the Model By-Laws. Such steps should include:
    a) each Board extending invitations to the Chairs of all councils to attend Board meetings;
    b) if the circumstances and needs of the organisation are such that doing so would be inappropriate, inefficient or would not otherwise enhance consultation between the Board, management and clinicians, a Board need not extend those invitations, however, the reasons why that decision has been made should be recorded in the minutes; and
    c) where a Board has determined not to extend an invitation to Council Chairs to attend Board meetings, they should implement a procedure whereby the Board shall receive reports from the Chair of each of the Councils within their district or corporation on a regular basis (at least quarterly) as to matters that fall within the remit of their respective Councils.

32. The Ministry of Health should review its processes for dealing with workplace complaints and grievances, including:
    a) simplifying and, where appropriate, consolidating its policy directives and guidelines relating to complaints, grievances, incidents, and workplace behaviour;
    b) establishing a central contact within the Ministry of Health for local organisations to seek advice about conducting those processes;
    c) establishing a process for monitoring the time taken by local organisations to conduct those processes; and
    d) establishing a mechanism for staff to seek review of workplace actions or decisions, external to the local organisation.

33. There should be a routine collection and collation of a granular data set directed to the wellbeing of the workforce (like that which the has been collected by the Chief Wellness Officer in the Sydney LHD) with a view to supporting and improving the wellbeing of the workforce within local organisations and across the system more generally.

Funding (chapter 19)

34. Once the public health system to be delivered by the State is identified through the system wide service planning process that I recommend, Treasury and the Ministry of Health should – with expert guidance – reformulate the funding model and devise appropriate funding structures to deliver that system. That process should consider the implementation of blended, bundled or other funding mechanisms to support the effective delivery of that system, and must not assume that any historical “base” figure provides a reliable or appropriate starting point.

Procurement (chapter 20)
35. NSW Health should develop and implement a systematic approach to embedding value based healthcare in its procurement processes, including developing and implementing clear and specific processes for: a) determining the components of value that are to be pursued in a particular procurement process; b) evaluating different options for procurement, including tenders, against each of those components of value; c) formalising and clarifying the role of CEC and the ACI in the procurement function, including by identifying the circumstances when and how those agencies should be involved in procurement activities; d) consulting as appropriate with clinicians, consumers, community members, suppliers and subject matter experts, in procurement processes.
36. NSW Health should develop and implement a systematic approach to monitoring the performance of suppliers at a system wide level, including developing and implementing clear and specific processes for: a) formulating clear and measurable KPIs, including with reference to value based criteria applied in the procurement process; b) monitoring those KPIs, including designating clear lines of responsibility for performing that monitoring; and c) obtaining feedback from and providing feedback to local organisations, including users of the relevant goods or services, in a regular and systematic way.
Innovation (chapter 21)
37. As part of a system wide approach to service planning and design, the Division of Clinical Innovation and Research must play a clearer role in coordinating the identification and development of innovations, facilitating their implementation Statewide, and continuing to support them until they are embedded. To do this effectively, the Division of Clinical Innovation and Research should clearly identify research priorities, including necessary translational research, which is critical to "demonstrate feasibility and the ability for these things of proven efficacy to be implemented in practice in ways that deliver better outcomes and don't lead to cost blowouts."
38. In setting research priorities, the Division of Clinical Innovation and Research should ensure that: a) Funding of research should be driven by community needs and priorities; b) Investment in innovation and research that aligns with capacity to improve health outcomes and include innovations that support prevention and/or are likely to have system management benefits; c) Support for translational research is enhanced, to enable the system to harness the benefits of innovations and prioritise those for wider implementation d) Investment in innovation should be evidence based with controlled introduction and ongoing monitoring to prevent indication creep or indiscriminate use, and to ensure costs are properly reflected and anticipated savings are realised.
39. There must be strong leadership (at the Ministry of Health and executive management levels) that empowers clinical and non-clinical staff to reduce unwarranted clinical practice variation, withhold low value care, and prevent over investigation, over diagnosis, and over treatment.
Conclusion (chapter 22)
40. NSW Health must be funded adequately to implement, embed, and sustain into the future the recommendations made in this Report. That funding should be ongoing, in addition to NSW Health's existing budget allocation, and quarantined for those purposes.
41. The Health Secretary should provide a report to the Minister as to the progress in implementing these recommendations at six monthly intervals following the delivery of this Report.