Submission No 9

THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO WORKFORCE ISSUES, WORKPLACE CULTURE AND FUNDING CONSIDERATIONS FOR REMOTE, RURAL AND REGIONAL HEALTH

Organisation: Can Assist (Cancer Assistance Network)

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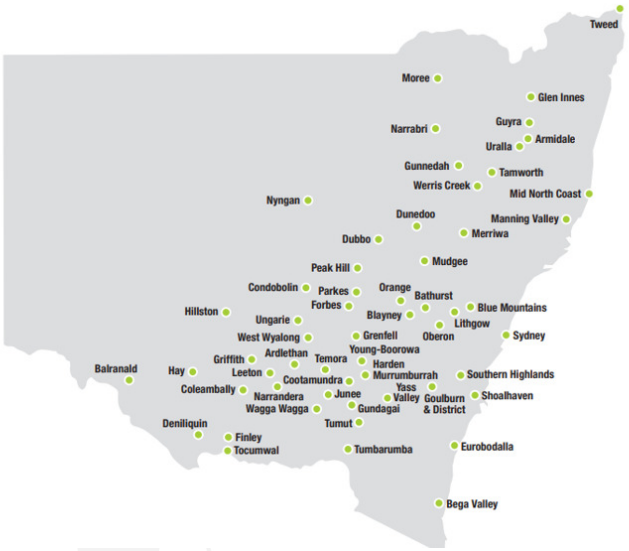
Dear Committee,

SUBMISSION FOR THE INQUIRY INTO THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO WORKFORCE ISSUES FOR REMOTE, RURAL AND REGIONAL HEALTH

Can Assist is the largest cancer support network in rural, regional and remote NSW; active in 56 branches with near 3,000 members. Over the last 30 years we have delivered near $50million in direct patient assistance with one goal in mind – equitable access to cancer treatment and care for non-metro residents. Our branches are operated by local volunteers who live and work in these areas and many have a detailed understanding of their local health landscape.

Can Assist Branch Map



Can Assist made two submissions to the 2021 rural health inquiry and offered our own personal testimony to the committee. We appreciate that the government remains committed to monitoring the practical impact of the Inquiry and hope our submission is helpful in this task.

Relevant background on the Can Assist Model in relation to workforce issues.

Our model intimately connects us with health professionals and cancer patient experiences across the state. Each year we deliver over 10,000 separate requests for financial assistance. Each client must be referred to a Can Assist client liaison officer by a health care professional (HCP) which is then followed by considered discussions with both the HCP and patient. Our most common interactions are with social workers, nurses, and doctors and hence our

submission will focus on workplace issues relating to these occupations. Note, Can Assist does not directly employ HCPs.

The views and observations below reflect the collective feedback and observations we have received during the course of our work combined with the results of an internal Can Assist branch network survey.

Social Workers and Nurses

Just under 5% of Can Assist branch survey respondents report an increase in social work and nurse staffing levels since the Inquiry handed down its findings in May last year.

1. **Rural Health work incentive scheme**; considerations and impacts

In theory, this is a generous scheme. Whilst it has resulted in some successful hiring, our contacts report mixed results. Overall, we would say that there is much confusion amongst our health workforce as to when and how they can be accessed**.** Many HCPs just don't understand the rollout parameters. After conducting an application process, they describe various unexpected eligibility "loopholes" and red tape.

For those applications that prove successful, they appear to generate a range of different outcomes that vary both across and within our LHDs. Below we describe our understanding of key features of the scheme and the unintended consequences being generated:

a. The bonus can only be offered after a failed recruitment process (usually means after 2 or 3 failed advertising rounds)

Given the high volume of fractional positions in our hospitals and the time lapse over any unsuccessful recruitment period it is not uncommon for a job initially advertised 0.4 headcount for example to become a 0.8 headcount or a 1.0 job. However, since this is then considered a new position, additional failed advertising rounds are required before bonus eligibility is re-established. This becomes a vicious circle for managers and unnecessarily elongates the hiring process.

We have received some reports of eligible applicants "holding off applying" until the position becomes bonus eligible.

b. Recruitment bonus eligibility is determined via cost centre as opposed to job type.

For LHDs where **equivalent** vacant positions are located within the same cost centre (e.g. social work department HNELHD) bonuses have been a highly effective recruitment tool, however in other LHDs where there can be multiple cost centres for **equivalent** vacant positions (e.g. cancer services in WNSWLHD) the impact is perverse; prospective employees of the same skill and experience within the same hospital are treated differently with respect to bonus eligibility. Not surprisingly our Can Assist branches within the WNSWLHD are dealing with very short-staffed social work departments. Our Can Assist branch in Orange reports a FOUR hourly weekly uplift volunteering workload due to the dire shortage of social workers there (which has incidentally only become so acute post publication of the Inquiry's recommendations).

c. Retention bonus is only paid if your cost centre has onboarded under the recruitment bonus.

Since the retention bonus is applied by the same logic, i.e., if your cost centre has onboarded staff under a recruitment bonus; it further promotes competitive behaviour for the same job within rural /regional NSW. Overall, the bonus scheme incentivises movement within the rural landscape, without necessarily attracting new talent to it. The essence of the bonus system rewards manoeuvrability as opposed to longevity and experience.

Anecdotally at least, it seems that where vacancies have been filled from a source other than an existing rural HCP position, they have been filled by the less experienced and younger HCP co hort. It is not surprising that it is the younger and less experienced HCP that will be most open to relocation. In the meantime, we are disrespecting our long serving HCPs, who are deeply rooted in our communities and less able or willing to move.

d. Bonus prorated according to clinical workload component.

This gives rise to various anomalies in pay structure. Whilst managers are typically highly trained clinicians, the nature of their job means they are officially allocated a low (or no) clinical hours. In some cases, this means managers are finding themselves paid less than their staff. Adding insult to injury is the fact given the current work force shortages, many managers do in reality spend many hours attending to clinical workloads, just not “officially” so.

e. Bonus amounts differ due to geographical remoteness.

Whilst on the surface this appears fair, and may well be so in our regional towns, there is a different dynamic in our rural and remote towns. Whilst a HCP may be “based” in a rural area they may be regularly (ie weekly) scheduled to work in a remote location – yet they are penalised with a lower bonus than their colleagues who are based in the remote area but frequently work in the rural location.

f. It is up to the facility manager to determine if a bonus application will be made.

Given the frustration surrounding equitable distribution of the retention bonuses, we are aware of some workplaces that have voted against applying for them. The resulting resentments and competitive behaviour that the incentives create mean that some hospitals have declined to take advantage of them.

Whilst great in theory, the rollout of the bonus structure has introduced elements of individualistic competition into an overall renumeration structure that has in essence been collectively structured. The approach has created both inefficiencies and inequities amongst our rural, regional, remote workforce. In effect it makes the case for across the board pay rises for all rural HCPs as it highlights the dangers of a piecemeal approach.

2. **Onboarding inefficiencies** remain a common complaint.

It is taking 8 weeks to 12 weeks to onboard staff in various LHDs (eg SNSWLHD, HNELHD). Multiple emails that require various sequenced tasks needing continual follow up from managers. Sometimes this means that prospective employees find other jobs in the meantime.

Whilst there appears to be a central onboarding operation for each LHD (people and culture) their efficiencies vary considerably. WNSWLHD for example report a high turnover of

recruitment advisors and slow onboarding processes, whereas the Murrumbidgee report better efficiencies and onboarding within 2-4 weeks. Similarly, the Murrumbidgee have been very proactive in hiring offshore nursing staff, where we understand they are now in the process of on boarding some 29 new senior nurse practitioners, who will not only staff our hospitals but offer much needed training to our predominantly younger and less experienced rural workforce. It certainly would be productive if good reforms / approaches could be adopted and shared amongst our LHDs.

3. **Unpaid overtime** remains a problem.

Whilst pre-approved longer shifts are paid, given the nature of the work most overtime is unintended and not known in advance. Time in lieu for social workers can be accumulated but only up to 8 hours or utilised within a 2-week time frame and staff are simply too busy to take it. There does appear to be distinct variations across the board – really depending on the individual manager as to how this is managed.

4. **Lack of Community infrastructure and housing a hinderance to attracting relocators across all health professionals.**

In many of the non-regional towns, accommodation - remains very difficult to find and house prices are no longer as deeply discounted in comparison to metro areas. Community resources are often in short supply. It is not uncommon to find the local GP books closed to new patients, and often difficult to find childcare rendering families reluctant to relocate.

5. **Fear of speaking out**

Another issue raised at the Inquiry which does not seem to have abated. Whilst we would prefer to provide more specific feedback around many of the issues raised in this submission, the constant request for anonymity prevents us.

6. **Workplace Culture – Social Workers feeling less valued**

This problem seems more prolific in the larger regional hospitals; however, we feel from the ministry to the media down – there seems to be a constant de-emphasis on the importance of social work.

From Can Assist's perspective, social workers play a key role in getting vulnerable patients into treatment and keeping them there for the duration. As per finding 12 of the Inquiry – some patients will experience severe financial stress and/or choose to skip lifesaving treatments. Social workers are the key to changing that reality for this cohort. Social workers are the ones who support patient *access* to available govt assistance (IPTAAS, Centrelink, carers allowance etc..), to external charities like Can Assist, and help patients to access - their own income support through superannuation etc…Once treatment has commenced, social workers play a key role in *keeping them there*. Many of our rural hospitals lack access to onsite psychologists and this gap is filled by social workers. Treatment anxiety is common for cancer patients, who struggle with the actual treatment procedures, (e.g radiotherapy masks and bunker enclosures) or who are triggered by the nature of the treatment (eg sexual assault victims).

Sadly, with many staff shortages often only more complex cases have access to a social worker so their tasks are often transferred to nurses, which simply is not their area of expertise, distracts them from their key responsibilities and reduces their overall job satisfaction.

7. **The Pressure to discharge**

This remains a major cause of stress for social workers. Prior to discharge complex assessments need to be undertaken which might include family dynamics, available community resources, NDIS etc... Whilst social workers are in fact trying to navigate the various barriers to discharge their work is too frequently interpreted as one of obstructing discharge. We see no change to this post the 2021 Inquiry.

8. **Staff wellbeing**.

We have heard of various "wellbeing" surveys of staff (eg "employees matter"), yet should the staff member responses indicate stress and mental health issues, they are simply alerted by a generically created email to seek help. Again, this may not pertain to every LHD.

9. **Job Insecurity**.

A statewide issue that is frequently raised with us and not yet resolved. This is primarily in relation to the 12 month rolling contracts that are issued via the NSW cancer institute. Many have been on rolling contracts for 10+ years and it is not uncommon to hear of HCPs working several years without any contract at all. Whilst this remains a problem for both social workers and nurses, it does appear to be more pronounced for social workers. This issue was raised at the 2021 Inquiry yet seems not to have been addressed.

The implications are considerable. In particular, the inability to secure a mortgage makes it very difficult to entice new workers and retain existing ones. For those lucky enough to belatedly migrate to permanent contracts, higher housing prices have seriously impacted their future wealth outlook.

Doctors

GP shortages remain acute, and we have not identified meaningful change post the 2021 Inquiry. Whilst some 20% of our branch respondents report an uplift in local GP numbers since the Inquiry, around 40% report a decrease. 60% of our branches report GPs as being the most important and urgent staffing shortage across the HCP workforce.

Anecdotally, some 80% of our rural GPs are foreign; sourced either via the Federal Government moratorium on foreign doctors trained in Australia or directly from overseas. This has been a successful scheme, not least because, it brings HCPs into the rural setting rather than encouraging movement within it.

The difficulty around credentialing foreign doctors remains onerous – starting with the AMC exam; if a small portion is failed, it will take a full year for the result to be reviewed. Once passed, doctors with 10+ years of experience (some in specialities) will need to be supervised by a fellow doctor for months until they pass through the accreditation phase – this is difficult and costly, especially in towns with GP shortages to start with. Whilst noting that this is primarily the responsibility of the Federal Government, cannot the state precipitate change to reduce the red tape and drive improvement where necessary?

With our hospitals understaffed by doctors, the State Government then asks doctors to be on call for the entire weekend and renumerates them a mere $15 an hour for this. If the same doctor wanted an emergency shift in a metro centre, they would be paid $3,000 for a shift.

With many of our rural hospitals serviced only by doctors in conjunction with their regular day job, they are overworked. In many towns, a doctor will only attend the local hospital for a level 1 or 2 triage.

We have heard of welcomed improvements to hospital telehealth; this has been particularly celebrated in LHDs that cover vast geographic areas such as WNSWLHD. It should be noted that this has also meant extra work for our nurses who then need to conduct the full patient assessments themselves.

Armidale has lost 12 doctors over the last 12 months – and whilst some relocated for personal reasons, others retired. Retirement is well known in advance and should be planned for years ahead. Yet even in the larger towns such planning appears absent; when the radiotherapy oncologist retired in Orange only one machine was operable for many months and Can Assist was forced to assist with travel and accommodation out of pockets to help patient costs associated with travel to Sydney.

For those towns where GP numbers increased over the last 12 months, successful hiring seems to have had nothing to do with State Government policy; but rather the private connections and network of the existing business. Moreover, for towns like Gunnedah and Cootamundra for example where GP numbers increased by a combined 7, 5 of these doctors were recruited from other rural towns, creating shortages there. The 6th doctor was sourced under moratorium policies, and the 7th from overseas (after a very long process).

Doctors report Federal Government grants as meaningful.

Concluding Remarks

We are grateful that this committee has been established so soon after the original inquiry and extend every encouragement in its investigations. We continue to see the weight of these workforce shortages falling on the shoulders of our rural volunteer base. At Can Assist, our volunteers do the heavy lifting and many have become quasi-HCPs in the process. More than half of our branches report additional workloads of up to 4 hours a week due to the HCP gaps they are forced to fill. This is a precarious and unsustainable situation. The sooner we all understand what is working and what isn't, the sooner we can arrive at lasting solutions. Can Assist stands ready to contribute and serve the Committee wherever it can in this task.

Yours sincerely,

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