Submission No 13

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

Organisation: Australasian College for Emergency Medicine

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Submission to the Select Committee on Remote, Rural and Regional Health

Introduction

The Australasian College for Emergency Medicine (ACEM, the College) welcomes the opportunity to provide comment on the progress of and issues relating to the implementation of Portfolio Committee No. 2 recommendations relating to workforce issues, workplace culture and funding for remote, rural and regional health services and programs.

1. About ACEM

ACEM is a not-for-profit organisation responsible for the training and ongoing education of emergency physicians, and for the advancement of professional standards in emergency medicine, in Australia and Aotearoa New Zealand.

As the peak professional organisation for emergency medicine, ACEM has a vital interest in ensuring the highest standards of emergency medical care are maintained for all patients.

2. Overview of the submission

In responding to the Inquiry, we draw upon the firsthand experiences of emergency medicine (EM) specialists and junior doctors working and training in emergency medicine, and we refer to, and build upon the College's recommendations made in our submission to the first Inquiry in 2020, as well as *ACEM's 2021 Workforce Planning Recommendations* paper, where we called for:

- A more strategic approach to health workforce supply and demand modelling;
- Increased investment across the health workforce, including emergency specialists and hospital inpatient services;
- Innovative approaches to address workforce maldistribution;
- Increased support staff to allow specialists to work to the top of their scope of practice; and
- A commitment to improving conditions for staff

3. Recommendations

1. Establish mechanisms to allow for consistent and accurate monitoring of (i) real time workforce needs and (ii) supply and demand modelling to inform medium and long-term health workforce needs.

2. There is a vital need for targeted initiatives to facilitate re-location of healthcare staff to regional areas.

3. Workforce models such as specialists networked across a number of regional sites and the Work in Work Out (WiWo) model should be explored.

4. Provide funding for General Practitioners, Rural Generalists, Career Medical Officers and other doctors working in regional areas who wish to undertake ACEM's non-specialist training programs.

5. Additional funding should be available to increase the number or non-clinical support staff (across various roles) in the ED, to allow emergency physicians to practice to the top of their scope.

6. Improvement and upgrades to staff amenities and associated support services are required.

4. Background

4.1 The Emergency Medicine Workforce

Our emergency medicine (EM) workforce is critical to improving emergency care is regional NSW. The EM medical workforce is a complex web of Fellows of ACEM (FACEMs), Career Medical Officers (CMOs), and ACEM Certificate/Diploma graduates. We work alongside General Practitioners (GPs), Rural Generalists (RGs) and other specialist physicians.

5. Summary of the Key Issues

5.1 Access Block

Access block refers to the situation where patients who have been admitted and need a hospital bed are delayed from leaving the ED for more than eight hours because of a lack of inpatient bed capacity. This includes patients who were planned for an admission but were discharged from the ED without reaching an inpatient bed, or transferred to another hospital for admission, or who died in the ED.

Year-upon-year there is a growing demand for emergency healthcare, from a population with ever-increasingly complex healthcare needs. In 2020-21, the median time for 90% of admitted patients to be transferred from the ED in regional NSW was 10 hours and 33 minutes. Access block is a whole-of-health system issue that results from bottlenecks in the system – when one part of the system is overloaded, demand builds up in other parts of the system. EDs are the most accessible part of the healthcare system. When hospitals and community services are overloaded, or inaccessible, EDs become increasingly overloaded, resulting in access block and ambulance ramping.

Access block is the single most serious issue facing EDs in Australia as it negatively affects the provision of safe, timely and quality medical care – placing both patients and staff at risk. Previous research has found that access block is associated with increased risk of complications, medical errors, and death, with greater costs to the healthcare system overall. Furthermore, access block is the leading cause of stress and moral injury, as well as career dissatisfaction amongst doctors working in EDs, leading to higher rates of attrition.

5.2 Inadequate Workforce Modelling

The depth and breadth of the FACEM role is crucial to enhanced clinical decision-making and the delivery of safe, high-quality emergency care. Whilst the past two decades have seen significant growth in the EM specialist workforce – staffing numbers are not keeping up with the continuing growth in demand.

There is a high concentration of EM specialists and Trainees in metropolitan areas, meaning regional hospitals typically must contend with significant staffing issues. ACEM's *State of Emergency 2022* Report showed that just 8% (one of 12) of ACEM accredited EDs in regional NSW met the minimum staffing recommendation for a senior emergency medicine workforce contained in *G23 Constructing an emergency medicine workforce*, compared with 27% (3 of 11) of ACEM accredited major hospital EDs and 7% (one of 15) of metropolitan sites.

5.3 Geographic Maldistribution

The persistent issue of geographic maldistribution makes it extremely difficult for regional health services to retain their EM workforce. Furthermore, the variable medical staffing models in regional hospital EDs limits the ability for EM trainees to do the majority of their specialist training in regional settings – which further exacerbates the shortage of junior doctors working across regional NSW.

In NSW, there is a marked shortage of FACEMs and trainees based in regional areas. Compared to metropolitan EDs, even fewer EDs in regional areas have sufficient FACEMs and SDMs when analysed against ACEM's G23 guidelines. These shortages lead to very challenging rosters and workloads for doctors who remain, resulting in significant burn-out, contributing to further attrition.

ACEM's *Future of Emergency Medicine Workforce* consultation confirmed that these factors were severely impacting both the delivery of emergency care, and the wellbeing of the FACEM and FACEM-Trainee, and wider EM workforce.

5.4 Inequitable Resourcing of Regional Hospitals

Many of the members we surveyed regarding their experience of working in regional EDs articulated fairly consistent themes of both enjoying the challenge of being exposed to the entire spectrum of undifferentiated patient presentations, emphasising they were much more 'hands-on' with patients than they are in major hospitals, and that this gave them great confidence in their decision-making and their ability to perform procedures. However, the rewarding aspects of working regionally were countered strongly by the lack of resourcing available to regional hospital EDs.

The resource issue is multifactorial, and has a profound impact on the morale of ED teams in regional NSW. Our members cite the dire shortages of hospital beds, the lack of referral pathways and unacceptably long transfer delays, coupled with the sheer distance to definitive tertiary/quaternary time-critical procedures.

Our members highlight constant staff shortages each shift, and the pressure for doctors to fill those gaps. Staff shortages were further compounded by the lack of clerical and non-clinical support staff. Our members describe feeling like they are in constant overdrive (within and outside of rostered hours) to keep the system functioning.

For larger regional EDs, EM specialists reported feeling overloaded with junior doctors (especially international medical graduates (IMGs)), and that they felt unable to keep up with their supervision loads and manage all of the other non-clinical aspects of their roles (e.g., referrals, home care, follow-up etc.) – whereas, smaller EDs reported struggling to get junior doctors period, and that whilst the nursing staff did their best, they endure significant safety concerns daily.

6. Recommendations

6.1 Improved Workforce Modelling

NSW now finds itself in the situation where (i) significant investment is required to improve the conditions for the existing healthcare workforce and (ii) there are significant shortages in the medical and nursing workforce.

There must be greater monitoring of workforce trends, and ongoing reviews by health services of their staffing requirements to determine staffing need in real-time. Consistent with *ACEM guidelines on constructing an emergency medicine workforce (G23)*, departments should determine the minimum safe number of staff – including the number of "senior decision-makers (SDMs)" within the facility at all times.

NSW Health can improve its workforce modelling by working in collaboration with the other States and Territories and the Australian Department of Health and Aged Care to establish a federated

medical workforce planning and advisory body, underpinned by accurate workforce supply and demand modelling to inform the needs of health and hospital services across NSW.

IMGs should not be viewed as a core component of workforce development initiatives. In instances where IMGs are recruited – to ensure effectiveness of this approach – the focus should be on making a larger investment into a smaller pool of recruits than making a smaller investment into a larger pool of recruits.

Recommendation: Establish mechanisms to allow for consistent and accurate monitoring of (i) real time workforce needs and (ii) supply and demand modelling to inform medium and long-term health workforce needs

6.2 Geographic Maldistribution

Addressing maldistribution of the medical workforce, including EM, must be a priority. ACEM supports exploration of new measures to facilitate sharing of staffing resource, that will also contribute to building the long-term sustainability of the health workforce. ACEM has identified that networked employment models are a feasible and relatively short-term action that could be operationalised. That is where a FACEM could be:

- Employed at a metropolitan hospital as their 'home' or 'hub' hospital, and work fractional appointment/s in regional hospitals; and
- Employed at a regional hospital and work fractional appointments at smaller rural hospitals

Critical in any such networked models would be:

- Stability of the FACEM appointment i.e., the same FACEM rotating their working arrangements across the group of hospitals, in a consistent manner; and
- Home and/or hub hospitals not recalling individual FACEMs from the regional site

An example of a flexible workforce model is the Work in, Work Out (WiWo) model, developed by the rural mental health not-for-profit organisation 'Outback Futures' for rural communities. This model creates a permanent workforce that rotates in and out of a rural community, whilst also staying connected with the permanent staff during times they are not there. This kind of model can create a permanent connection between visiting workforce staff and the community they serve, and ultimately leads to improved service delivery and less variability of care and importantly, helps reduce rates of attrition by providing increased support to permanent staff.

Locums

ACEM is cautions of the unintended consequence of a network or WiWo type of workforce model becoming the similar to the current locum arrangements across NSW. Whilst the locum model has a distinct purpose of meeting short-term workforce needs, it also brings disadvantages, such as significant costs, a higher risk of variability in care, and lack of continuity for patients and ED teams. While locums contribute to clinical care they provide limited or no contributions to teaching, administration and managing broader system issues within the service.

It is ACEMs view that the current expenditure on locum doctors would be better spent on targeted initiatives encouraging EM specialists and other healthcare professionals to adopt a network model or re-locate to a regional area.

Telehealth

ACEM notes that the use of telehealth in EM settings is an emerging and rapidly evolving area of clinical practice in Australia. There is an increasing range of service providers, delivering different forms of remote medicine, including direct patient care via telephone/video, secondary triage services, and clinician to clinician support. Our members acknowledge telehealth as a form of practice that has its place in medicine, but that more needs to be done to appropriately integrate it into the operation of the health system.

ACEM cautions that whilst telehealth has proven to have been effective in augmenting the delivery of emergency care services, ACEM's position is that in the context of emergency medicine, advice given

by telephone/video does not constitute a full medical assessment. Furthermore, the expansion of telehealth services is not an appropriate solution to address workforce shortages and maldistribution.

Recommendation: Develop targeted initiatives to facilitate re-location of healthcare staff to regional areas

Recommendation: Explore workforce models such as specialists networked across a number of regional sites and the Work in Work Out (WiWo) model

6.3 Emergency Medicine Skills Training

Staffing models in emergency care facilities where there are no FACEMs are variable and can include other specialists such as GPs, RGs and CMOs. Beyond EDs there are also many smaller rural and regional hospitals and other settings such as urgent care centres (UCCs) and GP clinics. While these settings typically see fewer patient presentations per year than larger regional and metropolitan hospital EDs, these facilities will see the same spectrum of patients with serious and immediately life-threatening conditions.

Despite seeing lower volumes of critically ill patients, doctors in smaller settings are expected to be competent to manage critically ill patients and maintain their skills indefinitely. Additionally, doctors in these settings are often not specifically trained in EM and do not always feel adequately skilled or confident to treat such patients.

ACEM already has a well-defined education pathway for other specialist doctors seeking to develop their EM skills through several ACEM Emergency Medicine non-specialist training programs. These programs were developed in recognition that a need existed to provide appropriate and additional training to other doctors working in settings where emergency care is provided.

Recommendation: Provide funding for General Practitioners, Rural Generalists, Career Medical Officers and other doctors working in regional areas who wish to undertake ACEM's non specialist training programs

6.4 Workforce Retention and Wellbeing

Extreme workloads for all ED staff, with continued access block and ED overcrowding, are leading to significant burn-out, and for EM workforce, impacting the longevity of their specialist careers. Whilst it is essential to invest in growing the health workforce, there must be a continued emphasis on recognising and supporting those working within the system, by understanding their personal and professional needs.

EM specialists have hourly task rates dominated by communication and clinical activities, as well as numerous educational and supervisory responsibilities. This is all within the context on the constantly increasing number of ED presentations per year.

However, ACEM's NSW members report that the ability of FACEMs to work to the top of their scope of practice is often compromised, with FACEMs often required to perform tasks that could be done more efficiently by others e.g., making beds, requesting and/or obtaining food and supplies for patients, escorting patients with non-critical conditions to tests or other wards.

This is also true of senior ED nurses who are undervalued resources for hospitals. They carry corporate knowledge and extensive system and clinical experience. However, due to increasing presentations and administrative demands, they often find themselves overburdened with numerous tasks e.g., management of rosters whilst also working a clinical shift, clerical duties that remove nurses from providing bedside care.

Therefore, increasing clinical and non-clinical ED support staff across a range of areas that will allow clinicians to practice to the top of their scope is vitally important and will provide immediate relief to ED teams that are managing extreme workloads.

Whilst access block is the leading cause of stress and career satisfaction amongst our FACEMs and trainees, measures such as making improvements to onsite conditions and support services for staff will go some way to addressing issues of workplace morale. This should be done in consultation with ED staff, and give consideration to issues such as:

- Improvements to, and in some circumstances, access to breakout rooms;
- Access to healthy and affordable food options 24/7;
- Providing clean and secure places to sleep;
- Access to onsite childcare services, with extended hours and provisions in place to support varied access for those working rotating shift patterns;
- Offering parking in close proximity to the building

Recommendation: Provide funding to increase the number of clinical and non-clinical support staff (across various roles) in the ED, to allow emergency physicians to practice to the top of their scope

Recommendation: Improve and upgrade staff amenities and associated support services

7. Contact

Thank you again for the opportunity to provide this submission. If you require any further information about any of the above issues or if you have any questions about ACEM or our work, please do not hesitate to contact [redacted]

Yours sincerely,

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Australasian College for Emergency Medicine