Legislative Council Inquiry into Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote New South Wales

HSU Response to Supplementary Questions

1. *In your submission you talk about the need for a review into staffing levels across regional and rural health services? Can you inform the committee as to how you would like to see the review carried out and what the focus of it should be?*

As Mr Hayes stated in his testimony [p5]: 'When we talk about doing reviews, we would like to see an element of transparency and independence in those reviews. Many of the reviews are done by chief executives or their delegates under the ability of their financial constraints. So it becomes a reactionary not a proactive review. We would like to contribute to a proactive review that is going to say, "This is where it needs to be." It may not be able to be achieved but this is what is real.'

Ideally, any review would be conducted independently from NSW Health under a leader with high-level experience in public health administration. The Review of the Operation and Management of the South East Regional Hospital could be cited as a rare example of such an independent process.

In March 2017, a year after the new hospital was opened, there were widespread and escalating complaints of mismanagement and a toxic working environment. In reaction the Minister for Health commissioned Associate Professor Michael Reid of James Cook University, the former Director-General of NSW Health and Queensland Health to lead an inquiry with the following terms of reference:

1. Analyse and assess the role of Hospital and District management in establishing the Hospital's processes and procedures in transitioning to the new Hospital
2. Identify any deficiencies, including the nature, extent and causes of any deficiencies, in the management of the Hospital
3. Assess mechanisms for clinician and staff engagement and communication and their potential impact on culture/morale at the Hospital and staff turnover
4. Assess system, process and capacity to detect, respond and to manage emerging critical issues within the Hospital
5. Provide a final report and recommendations in relation to any changes to accountabilities, policies and practices that may assist in defining the future directions for the management of the Hospital.

The wide parameters of this brief allowed for an extensive investigative process, and by a combination of confidential submissions from and in-person interviews Associate Professor Reid and his team heard from a comprehensive range of interested parties. The scope of these consultations can be seen from a list of the contributors which, well as a number of confidential participants, included:

Board of the Southern Local Health District
Medical Staff Council
Asset Manager
Amanda Adrian and Associates
District Director Clinical Operations
Manager Workplace Relations
Senior CT Radiographer
Nurse Manager
Administrative Officer
Director People and Culture
Director of Medical Services
Hospital and Security Assistant
General Surgeon
Member for Bega, Minister for Transport and Infrastructure
Finance Manager
iPM Support
District CE
Director of Obstetrics and Gynaecology
Director of Medical Services, Eurobodalla
A/Executive Director Medical Services
VMO Anaesthetist
Chief Information Officer
Senior Registered Nurse Theatres, Anaesthetic and Recovery
Director of Critical Care
Integrated Services Manager
Pharmacy
Cluster General Manager
Allied Health Manager
Business Manager
Orthopaedic Surgeon
Registered Nurse, Theatre
GP Anaesthetist
Executive Director Nursing and Midwifery
RN Theatre
Nurse Manager Leadership and Development
Orthopaedic Surgeon
Health Infrastructure NSW
NSW Nurses and Midwives Association
Executive Director Clinical Governance and Organisational Effectiveness
Chair, SNSWLHD Board
Director of Nursing
Senior Dietician
Executive Director Finance and Corporate Services

Crucially, Associate Professor Reid's brief included a 12 month follow-up to report on the extent to which his recommendations had been implemented and what the effects had been. This extra step, too often omitted from the familiar review processes, created a more stringent compliance requirement than is the case when administrations are not held accountable for their implementation and outcomes.

The HSU would like to see a state-wide review of public health staffing in NSW should be conducted along similar lines. As well as stakeholders within the state it should consider staffing establishments Australia-wide and internationally with the objective of determining benchmarks for operational levels and skill mixes for each hospital in the state.

2. *Your submission also recommends that the NSW Government initiates a specific attraction and retention bonus to encourage workers to take up positions in regional, rural and remote health services. Does the NSW Government currently provide any incentives for health workers in rural and remote areas?*

There is a range of initiatives set out in the NSW Government's submission to this inquiry in Chapter 12: *Rural, regional and remote health workforce challenges and opportunities* [p46]. For the areas of HSU coverage the most relevant are:

- NSW Rural Allied Health Postgraduate Scholarships – provides scholarships of up to $10,000 for clinicians in rural health services to assist with postgraduate study expenses..
- Workplace Learning Grants – provides financial support to groups of allied health professionals and/or allied health assistants to develop their knowledge and skills.
- NSW Rural Allied Health Clinical Placement Grants – provides grants of up to $750 (or $1,000 for Broken Hill) to subsidise travel and accommodation costs associated with rural clinical placements.
- NSW Rural Allied Health Undergraduate scholarships – provides scholarships of up to $9,000 for students from rural backgrounds undertaking undergraduate studies in allied health leading.
- Rural Allied Health Locum Program – provides locum coverage to sole allied health practitioners so they can access professional development and leave.
- Drought psychology positions – six new Senior Clinical Psychologist positions across drought affected areas as part of 2019 election commitment funding.
- Palliative Care Allied Health enhancements – 18 palliative care allied health positions (one per LHD/ Network) were funded in November 2018. These are permanent positions to address recruitment challenges in the rural LHDs for temporary contracts.
- Aboriginal Allied Health Cadetships – aims to increase the number of Aboriginal people working in the allied health professions across NSW.

In response to our enquiries HSU organisers in rural, regional and remote areas have reported no knowledge of these measures being implemented to any effect.

Organiser Mark Jay, who appeared before the Committee on 19 March has made extensive inquiries within his area of the South Eastern NSW Local Health District and, far from reporting any benefits, the workers and administrators he questioned merely emphasised the many needs that are not being met and conditions that hamper recruitment and retention for non-metropolitan facilities. Below is a representative sample.

> *Often rural communities have limited rental accommodation. The Bega Valley is known to be very difficult to rent houses.*
>
> *Many years ago most Hospital had staff accommodation which was a lifeline for students and new graduates. New graduates traditionally lack monetary resources. Safe, clean and affordable accommodation in staff quarters provided a attractive proposal for new staff. Over many years their resource have vanished.*
>
> *Most rural radiographer act independently without direct assistance from radiologists. They are therefore advanced practitioners. There is no allowance for that.*
>
> *The incentives that are offered to my knowledge at present, in my opinion, are not enough and do not genuinely attract staff, in my case pharmacists, to the area.*

For intern training positions, in Southern LHD we offer 3 x0.5 FTE intern pharmacist positions. Having part time positions is a real disadvantage for us in attracting intern pharmacists to the area, as they then need to find another workplace to complete full time work. The national intern training program is based on full time work expectation. Finding a community pharmacy to agree to employ a part term intern pharmacist is difficult and we had a number of candidates in 2020 withdraw because of the part time nature of the role. Attracting intern pharmacists to rural sites is essential for workforce planning and retaining these people in rural sites is an essential part of business that we have not been able to meet.

Access to professional development is difficult, as our ability to attend face to face education, which is typically located in Sydney, leaves the team short staffed as we do not have the casual pool to draw from to cover this education time. Casual staff are difficult to employ in a rural area and providing back fill is difficult to facilitate.

One incentive I am aware of for rural NSW health staff members that applies to the Bega valley is in the increase in salary sacrifice opportunities that they can utilise, however I am told this does not apply to rural sites that have a 'base hospital', which seems to defeat the purpose, as base hospitals are generally located in regional areas.

These incentives that are offered are also not widely publicised and made readily available to staff. Many of these incentives are only known by word of mouth. These incentives should be included on job listings and LHD websites.

Many services, especially in allied health and pharmacy, are being underutilised due to the low staffing levels and difficulty attracting and retaining the right clinicians. If managed appropriately, we could further improve patient services and improve care, improving our patient outcomes.

The NSW rural allied health postgraduate scholarship for example, is a great incentive to offer, however for pharmacy examples, it offers $10,000 scholarship, for an approximately $30,000 degree, leaving the staff member $20,000 out of pocket. Should this person not work in rural NSW health, then they could apply for a pharmacy guild scholarship of the same value. Therefore, NSW health is just meeting other expectations, rather than exceeding them. Furthermore, in 2021 for example, applicants of this scholarship are likely to be told of the outcome of their application in mid-June, despite the first census date and therefore course fee due date is months prior to this date. So the student must commit to the course prior to the knowledge of if they will receive a scholarship. This is not encouraging staff to further their education.

On the subject of incentives that could potentially have a positive effect, one member commented that they could include:

- *actual mentoring programs for junior health professionals for professional development*
- *providing career development in one rural site, as across the LHD is not acceptable for most staff as they have chosen to establish themselves in one town, not one LHD, which is not commutable.*
- *providing opportunities for career development in the appropriate clinical setting. The focus appears to be grade 1/2 are majority of workforce, with few higher level positions. Clinicians are then leaving the district to find full time grade 3/4 positions due to a lack of opportunities.*
- *provide management training so that teams are better managed, we are trained as clinicians not managers.*

- *provide adequate clinician to patient ratios, including for allied health, SHPA has clear guidelines for pharmacist: patient ratios, yet our FTE is half of the recommendations. In recruitment, one of the first questions to be asked is 'how many beds is the hospital?' and 'how many practitioners?'. These low ratios are not attractive to potential staff members. Furthermore, many allied health are not funded at all to provide inpatient services, which shows a lack of value of the service by NSW health and is discouraging for staff, potential* and actual.

3. *You have called on the Government to increase resourcing for regional, rural, and remote ambulance services, to match or exceed 61.9 qualified paramedics per 100 000 people.*
    a. Do you have some examples of locations in rural NSW where the number of paramedics is below this?
    b. How does that standard compare to communities in metropolitan areas?
    c. What impact will the Government's commitment of additional paramedics have on this issue? Is there enough?

Our call for the government to increase resourcing for ambulance services to match or exceed 61.9 paramedics per 100 000 people is based on data from the Productivity Commission's 2020 Report on Government Services where this figure represented the average of Queensland and Victorian paramedic staffing levels. This report showed paramedic staffing in New South Wales to be lagging significantly behind at 37.7 paramedics per 100 000 people. Since making our submission, the Productivity Commission released 2021's Report on Government Services, showing a modest increase in NSW Paramedic staffing to 40.8 paramedics per 100 000 people.

a. Data on ambulance staffing levels is only publicly available on a state-wide basis, and there is no breakdown comparing metropolitan and non-metropolitan staffing levels. However, the lived experience of our paramedic members in the regions tell the story. Often single paramedics are left to cover whole towns while critical patients are transferred to larger hospitals. A single paramedic is not able to safely provide the complex clinical interventions that make the difference in the pre-hospital care setting.

b. While metropolitan ambulance stations are also understaffed, the impact is different as transport times to major trauma hospitals within metropolitan zones are far shorter.

c. We can presume that much of the increase from 37.7 to 40.8 paramedics per 100 000 people seen between the above-mentioned Productivity Commission reports is attributable to the State-Wide Enhancement Project. However, in order to reach 61.9 paramedics per 100 000 people, NSW would need an additional 1714 paramedics above current staffing levels. This is far beyond the scope of the NSW Government's State-Wide Enhancement Project. While the additional 700 paramedics are a welcome improvement, this should simply be seen as a first step towards catching up to instate jurisdictions. NSW response time performance continues to deteriorate and, according to the latest Productivity Commission Report on Government Services, is the second worst in the country – part of the problem here is that the Treasurer has not released enough funds to actually backfill any of the 700 additional staff, meaning that whenever any of them are injured or call in sick, the community remains deprived of the benefits of increased staffing.

Highlands Health

Progress on Implementation

South East Regional Hospital Review

Michael Reid

Adrian Nowitzke

April 2018

Introduction

The purpose of this Briefing Note is to report on the progress of implementing the May 2017 "Review of South East Regional Hospital (SERH). In preparing the Briefing Note, individual interviews were undertaken with the NSW Ministry of Health, the Executive of the Southern NSW Local Health District (LHD)and the SERH *(see Attachment 1).* In addition, a meeting was held with the Board of Southern LHD and with members of the Medical Staff Council at SERH.

At SERH an email was sent to all staff offering a meeting with the Reviewers should they wish. The extent of response was indicative of the desire by all to assist in cultural improvement. In addition to individual interviews, a detailed brief was provided to the Reviewers. This brief, which is regularly updated by SERH Executive and provided to the Board, monitors progress of each recommendation of the original Review.

This Briefing Note does not endeavour to replicate the oversight of progress against each recommendation. Rather, it provides oversight of the overall intent of the original review to improve the culture of SERH.

The Briefing Note reports against principal themes of the initial Review viz Leadership, Clinical Engagement, Clinical Governance/Planning, Human Resources, Bullying/Harassment, Management Roles and Responsibilities and Budgeting.

This review of progress has been undertaken less than a year on from the initial Review. It should be emphasised that several years foci will be necessary to fully implement the desirable transformation in culture.

A number of issues were raised during interviews which were either outside the scope o the Review or specific to particular areas of the Hospital's operations. These were verbally relayed to Executive for their deliberation.

Overall Assessment

The Southern NSW LHD in general and the SERH executive leadership specifically, should be congratulated on the attention they have focussed on implementation of the SERH Review. Most people interviewed reported noticeable improvement to the "look and feel" of the hospital. Many people particularly commented on the significantly enhanced medical engagement in models of care/clinical governance.

As emphasised, this progress report is occurring less than a year on from the time of the Review. Full implementation of the recommendations, particularly those related to culture, collegiality and leadership will be slow and fragile burns over a number of years.

The next phase of implementation should focus on:

- the development of a comprehensive CSP
- the development of a complementary workforce plan
- addressing the ongoing problems in theatres
- exploring the options to reverse patient flows into ACT from the Bega Valley Health Service
- ensuring the administrative personnel appointments provide the intended value add to the operations of SERH.

Leadership

Locally, there is strong support for the Hospital General Manager, who provides energetic and caring leadership. She remains key to the ongoing transformation at SERH and should continue to be supported and enabled to be successful. The visibility of the new Chief Executive of the LHD, despite the recency of his appointment was noted, particularly by the medical personnel.

The departure of the previous Director of Medical Services (DMS) and the interim appointment has been well managed, but it is important that a permanent replacement be appointed expeditiously. It is understood that such an appointment is progressing rapidly.

The Director of Nursing has been working with nursing staff, particularly the Nurse Unit Managers (NUMs), to assist them develop their clinical leadership skills.

The initiatives of the GM with respect to rewards and recognition and social events are all contributing to re-establishing good staff morale. Other small but important initiatives recommended in the Review and subsequently implemented have included improvements in physical surrounds and the wearing of nametags.

Clinical Engagement

The SERH Review proposed the creation of a cross disciplinary senior leadership group that "models the values of the District and demonstrates exemplary leadership behaviours, including their own leadership development".

Such a group has not yet evolved, but other mechanisms for cross disciplinary leadership forums have emerged which are very encouraging. The ever-increasing engagement of the medical workforce in forums such as the Senior Leadership Group and Clinical Governance meetings is particularly pleasing.

Clinical Governance / Planning

Substantial progress is apparent in relation to both the process and culture of clinical governance. The revision and modernisation of the models of care has been completed or is progressing with respect to maternity, paediatrics, Emergency Department, Surgery, ICU and Subacute Care. Such progress is a credit to all involved.

The operating theatres however remain an area of concern, where a targeted focus is required to restore operational efficiency and teamwork. The absence of a permanent Nurse Unit Manager is impacting achievement of change. Because of the central nature of operating theatres in the productivity of a hospital, this is concerning.

The Reviewers propose that an external person with expertise in managing similar theatre complexes is engaged to redesign the productivity, cautioning against the belief that the problems will be adequately addressed solely through a NUM appointment or a high level consultancy approach.

The focus on use of benchmarking data in Bega Valley Health Service (BVHS) Quality and Safety meetings and support and encouragement for this development by the LHD Board is also pleasing. Membership of the Women's Health Association for benchmarking and collaboration purposes in Maternity is suggested.

One member of the medical staff indicated there was still inadequate communication between staff at handover. Also suggested was the need to enable clinical reviews to be undertaken at times that enabled maximum staff attendance.

The recommended development of a clinical services plan (CSP) has not yet been completed. With the assistance of the Ministry, planning meetings were held with staff. An Activity Review resulted from these meetings. This Activity Plan should form the basis of the next phase – a comprehensive CSP.

Human Resources

At the *operational* level, recruitment processes, staff development and performance management still appear far from satisfactory. At the *strategic* level, such areas as improved workforce satisfaction, engagement and workforce planning need ongoing attention.

Inadequate attention has been focussed on the development of a workforce plan which highlights major future workforce requirements in line with the clinical service initiatives. This gap is understandable given there is no fully developed CSP. The development of a more detailed CSP and workforce plan should proceed in unison.

One of the recommendations of the Review was to enhance administrative support through the appointment of additional administrative support officers. A number of people interviewed, whilst fully endorsing the intent of the recommendation, claimed it was poorly implemented with some appointees subsequently resigning. Ongoing oversight to realise the benefits of the administrative support personnel is required.

There remains an ongoing high dependency on locum support, and a strategy is needed as part of the workforce plan to address it.

Bullying/Harassment

Successfully addressing the apparent systematic and long-standing bullying and harassment at SERH will require a long-term horizon. Nevertheless, there have been satisfactory progress by the SERH Executive over the past year. Specific programs and training sessions have been introduced with the intention of highlighting and addressing poor behaviours. Clearly the development of a Senior Leadership Group including senior clinical personnel that demonstrate appropriate leadership behaviours will enable more rapid and sustainable behavioural change amongst all staff.

The SERH Behaviour Program, *"Above the Line all the Time"*, has been implemented throughout the hospital. A *"Nursing Cultural Change Program"* has been developed and implementation commenced. These are positive programs which were generally well commented on during interviews.

Management Roles/Responsibilities

The roles and responsibilities of the cluster managers viz a viz the district executive still needs clarification. The existing lack of clarity has been recognised by the new CE of the LHD as an important area to address. Good governance would suggest that enabling optimal local autonomy within clear parameters established by the LHD is desirable.

Budget

The SERH Review recommended a more transparent budget process throughout the LHD that gave better insights into the relative performance of services both within the LHD and between comparable hospitals in other LHDs. It is pleasing to note that the changed budget process is on track for implementation in the 2018/19 financial year.

One specific issue highlighted in the Review related to the benefits of arresting patient flows out of the Bega Valley Health Service (BVHS) into ACT. If service to public patients can be provided more efficiently at SERH, by comparison to the price paid to ACT Health, this will help alleviate the overall budget issues confronting the LHD. This will require detailed discussion with local GPs and greater certainty of timeliness for elective procedures.