Supplementary Submission No 276b

INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NEW SOUTH WALES

Organisation: New South Wales Medical Staff Executive Council (NSW MSEC)

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The current Local Health District model has been in place since 2012. Under this model centralised planning functions of NSW health (Statewide Services division) were removed. Whilst the model was supposed to increase local decision making in the planning and provision of services, the reality has been otherwise in many LHDs, with little engagement between the LHD boards and local communities or with LHD clinical staff, as evidenced by People Matter Surveys, NSWMSEC survey of MSC Chairs (see website), Board Minutes and the Auditor General Report 2019. With the LHD structure, the state government maintains a level of distance and deniability if something goes wrong in healthcare. "That is a problem for your local health District" has been a frequent response when staff or patients raise concerns to the Minister or Ministry of Health, and yet there are few avenues for the staff or community to raise an issue beyond the LHD when the LHD has failed to resolve it in the current structure.

Following the Garling Enquiry of 2008, the Pillars of BHI, ACI and CEC and current LHD structure were established in 2012, but the pillars have not been adequately resourced to take on the role that was envisioned by the Garling report. There have been ambiguities in what is their role and what is the role of the LHDs. For example, the ACI was set up to provide clinical leadership and were to be combined with financial planning resources to conduct business cases and implement system changes and improved models of care across NSW. No centralised ongoing financial or systems change management funding has been provided. This under-resourcing limits the potential of the ACI to fulfill its statewide role of ensuring uniform models of patient care.

Improvements to the current NSW Health systems are needed in the following areas;

1. **Service Planning:** This model needs to provide **statewide service planning** and funding decisions, based on healthcare and population needs, free of political agenda in selecting and resourcing appropriate rural/regional hubs sites with uniform services for key conditions.
    a. Devolved model has limited ability to develop major new services.
    b. Limited ability to achieve uniform service delivery in core services (eg treating heart attacks by access to a cath lab 24/7 not routinely available in all LHDs, despite most having the necessary infrastructure) .
    c. No current imperative for each LHD to have uniform staffing and models of care for hub services for a given role delineation of a service eg presence of nurse CNCs, number of registrars based on a services' patient activity level as two examples.
    d. Service planning needs a vision for the level of service to be provided in key hub locations with uniform tools/staffing matching the service level.
    e. Business cases need to be state level with sufficient financial expertise to identify savings across agencies eg building local capacity for regional and rural healthcare services is definitely cost effective when savings in patient transport and wasted beddays across all sites are considered.

2. **Independent oversight and Governance:** Establishment of broader, centralised, objective, openly reported oversight systems of LHD clinical governance, corporate performance and hospital performance are urgently required.

a. The current system is almost completely dependent on self- reporting by the LHDs.
b. The CEC, ACI, BHI could have a monitoring and supervision role.
c. All avenues of data could be used in monitoring (not just those provided by LHDs) and should include routine reporting cards from Clinicians and communities/health councils.
d. The auditor general report April 2019 recommended more work was needed on "a framework that better reflects all the performance monitoring and reporting that is done…" Many of the recommendations of that report have not yet been implemented. The current system seems a little like lodging an annual tax return where these is little capacity at the tax office to actually check the contents.
e. The Auditor General Report April 2019 stated "There are areas where accountability and oversight can be improved including;
    i. Continued progress in moving toward patient experience, outcome and quality and safety measures
    ii. Improving the health performance framework document to ensure it is comprehensive, clear and specifies decision makers
    iii. Greater clarity in the nexus between underperformance and escalation decisions, including governance-related performance measures
    iv. More rigour in accountability for non-service activity functions including consumer and community engagement
    v. Ensuring performance monitoring and intervention is consistent with the intent of devolution."

3. **Objective avenues, independent of LHDs, are needed for conflict resolution**.
Establishing a KPI for engagement with clinicians and MSCs, with a measure of issues raised by MSCs to LHD boards would assist in provision of early intervention for non - clinical management functions. Better systems in this area are likely to have great benefits in decreasing bullying within the organisation and in turn may save a lot of money, as unresolved issues can fester and escalate. Benefits of reform in this space may include;
    a. A decrease in the spending on legal action and the employment of external consultancies to generate reports and arbitrate. NSW Health spent $29 million on consultants and nearly $14 million on legal costs in 2020. Whilst not all of that would relate to issues of conflict resolution, there may be substantial savings in this space.
    b. Timely identification and performance management of poorly performing administration staff. Cases where administrators have not performed their duties in line with mandated NSW Health policies and procedures for fairness should prompt action to prevent repetition of poor management practices.
    c. A shift to earlier objective assessment, more apologies when things do go wrong, with openly disclosed steps for improvement, would build staff confidence.
    d. Providing an avenue for complaints/concerns to be objectively assessed free of the LHD at an earlier stage (eg via the pillars) may be a significant and cost effective improvement.
    e. Provision of formal external oversight to implement reforms identified in an episode of suboptimal LHD performance is also needed, rather than charging the

same administration, who may have presided over suboptimal performance in the first place, with the lead role of addressing the situation. This is not a robust model.

4. **Role of the LHD boards as independent oversight bodies, independent of the CE is not always clear and effective in practice.**
    a. Relationship of CE and board chair described as "too cosy" in one case by Auditor's report.
    b. There is a lack of clarity on what is "operational" (role of management) and what is "strategic" (role of board) – see Auditor Gen report, particularly in areas such as staff complaints.
    c. The role of Boards can be seen as "rubber stampers", rather than involved in decision making, for example in the negotiation of service agreements.
    d. The Boards vary considerably in their level of experience and in their performance – the standard of minutes can show this marked variation, and yet each and every LHD board is responsible for very large budgets of public money.
    e. The people of NSW would be better served by applying uniformity to the level of financial and corporate board experience to the membership of all of the 15 LHD boards.
    f. There is a need to achieve a uniform standard of minutes and reporting that is sufficient to meet the challenges of running a large corporation. Rural LHDs are often relatively less experienced and may be particularly disadvantaged.

5. **Involvement of clinicians in decision making** needs improvement.
In the words of the Auditor General's report on Governance of LHDs April 2019, "Better clinician engagement in LHD decision making was a key driver for devolution. This engagement has not met the expectations of devolution and requires attention as a priority."
The disengagement of senior clinical staff from management decisions is at the highest levels seen in decades. There needs to be a deep respect for the excellent clinical staff (medical, nursing, allied health professionals) who work within NSW Health and a re-engagement of senior clinicians in service planning and resource utilisation decisions, rather than a tendency to use external consultants. Excellence in healthcare can only be achieved with a team approach where clinicians and administrators work together to establish the best possible services for patients and strive to continually improve them.

Disengagement of clinicians extends to other parts of the structure. In the current structure. the ACI is not involved in running a budget or in determining key strategic service delivery decisions. It therefore has little power to implement and oversee any clinical improvements or innovations it suggests. This has led to disengagement by senior clinical staff from ACI involvement. A wealth of ideas can be generated by highly experienced clinicians in ACI meetings, but, as they do not lead on to any change or any funded programs, there is little return on investment to the senior staff for their time.

There needs to be a rebuilding of/and respect for, the role of senior clinicians (medical, nursing, allied health) in clinical service decision making. There have been declining numbers of doctors on board membership since their creation in 2012.

6. **Stop spending money on consultant reports** from organisations such as KPMG, PWC and others. Re-invest this $29 million per year more wisely. These reports are often commissioned by management with their own agenda and terms of reference and are not always released unredacted, or if they are, the recommendations of such reports are not always actioned. The reports vary in quality. The value of spending in this space needs to be seriously questioned and reconsidered. Senior clinicians within the organisation and within the pillars may be able to provide a much higher level of analysis and clinical experience to some of these strategic and operational questions at a much more economical rate, allowing investment and greater staff resources within the organisation and the pillars. Companies such as PWC and KPMG often send relatively junior staff, with little clinical experience, to interview the much more experienced senior medical staff employed within NSW Health in compiling their reports.

7. **Data combined with action is needed to improve systems**:
   A wealth of data is collected eg BHI, People matter survey. Actions to remedy and assist underperforming LHDs or hospitals, rather than collecting the data are needed. The Health care management system needs to shift to an open, transparent, self-improving culture, as is required in clinical performance systems (iiMS system).

   a. Auditor General report identified a need for greater clarity in escalation decisions and triggers for the System Performance Branch to provide support to an LHD and scope for earlier intervention.
   b. Routine oversight needs to include additional KPIs. The BHI generates a wealth of performance data. Not all is taken into account in performance frameworks.
   c. Rural LHDs in particular need action to assist and improve clinical performance to be in line with metro outcomes. There is also a need for an access time KPI for interhospital transfer times to tertiary centres (rural hub or metro) – to ensure patients waiting for beds to access care are not unfairly disadvantaged. Such a KPI is in the best financial interests of NSW as wasted beddays of patients awaiting transfer use a large % of the healthcare budget. Undue focus on emergency access times alone ignores a key part of the system.

8. **Workforce distribution**:
   a. Business cases to establish services and additional regional/rural specialist positions must be at a state level, if the inequities of per capita specialist distribution is to be addressed, otherwise poor cost effectiveness such as spending on patient transport /locums, rather than investing in locally based patient care, cannot be fixed.
   b. The myth that the reason regional/rural centres lack sufficient specialists per capita is solely due to specialists not wanting go rural needs to be dispelled. In many cases there is no funding for a position and to establish a new position takes years of business cases and lobbying by existing specialists in order to gain approval for additional workforce. This must change if the per capita understaffing of specialists in regional and rural areas is to change.
   c. NSW needs to be smarter about removing barriers to allow this shift of specialists workforce to rural hubs to occur.
   d. Investments in locally based regional and rural services is more cost-effective, saving enormous amounts of money otherwise spent on patient transportation

($116 million 2020), fly-in services and locums and on wasted beddays of patients awaiting transfer to and from tertiary metropolitan centres.

e. Services requiring timely access (such as emergency care, cardiac care, cancer services) cannot be supplied equitably and cost effectively in a Sydney-centric model for NSW.

9. Stable referral pathways are needed to guarantee regional and rural patients timely access to care when they do require transfer to either a regional or metropolitan centre. The vulnerability of these systems of access have been particularly exposed in the COVID era with the additional strain on the system, underlying the imperative to develop locally based regional services to higher levels of independence.

10. Telehealth. Telehealth can be a powerful tool to support patients and clinicians in regional settings.

a. poor substitute for locally based clinicians and workforce who can provide ongoing care for patients.
b. Telehealth model needs to consider not only the management of the acute problem, but the medium and long-term follow-up needs of the patient
c. Models must document and hand over care to locally based health care services to provide for the ongoing needs of the patient.
d. Paying for remote telehealth services that have no connection with, or fundamental knowledge of local areas, is a very poor investment and a potentially dangerous health care model.
e. Successful telehealth models need to fundamentally support the on the ground clinical staff and not seek to replace them.