Supplementary Submission No 2a

INQUIRY INTO EQUITY, ACCESSIBILITY AND APPROPRIATE DELIVERY OF OUTPATIENT AND COMMUNITY MENTAL HEALTH CARE IN NEW SOUTH WALES

Name: Mr Marc Lamond

Date Received: 5 September 2023

Monday, September 4th, 2023.

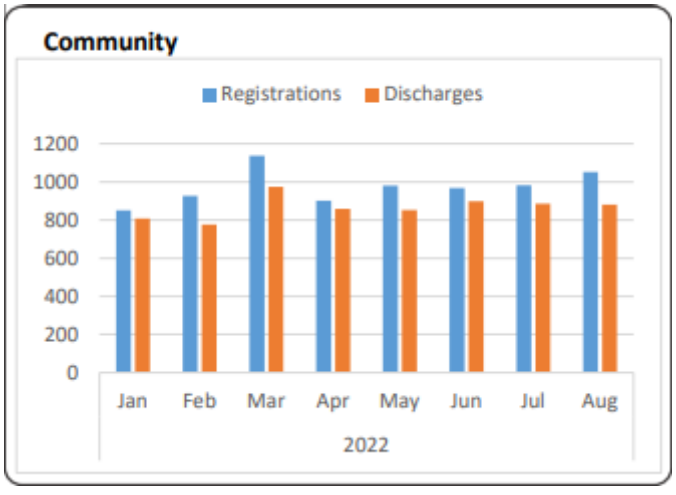
Dear Honourable MP's,

I write to you, providing another submission to the inquiry surrounding the equitable access of community mental health in NSW, particularly NSW Health. My name is Marc Lamond, I have been a nurse in the public community mental health sector since 2015, working in a district within the Sydney metropolitan area. My previous submission I asked to have my identity withheld – Now that we have been given advice from the executive director of MH within the ministry, I am happy to have my name endorsed to this submission. However, as part of that, I do need to state that my opinions are not reflective of those held by NSW Health.

I wanted to provide a supplementary submission, which holds my experiences with community mental health up against the NSW Health Nursing award of 2022. I hold the opinion that in my near 10 years of experience, the domain of "case management" or long-term ambulatory care, has never met the criteria outlined in section 53: Staffing arrangements. I will refer to our patients as "consumers" or "clients" or "clientele" throughout this document.

53(iii) (b) – *Workload assessment will take into account measured demand by way of clinical assessment, including acuity, skill mix, specialisation where relevant, and geographical and other local requirements / resources.*

There is limited data available to us related to measured demand in my clinical service area. Options include registrations vs discharges, and / or ambulatory client activity data. The only data readily available is from the 2022 calendar year from January – August (See below)



As shown in new registrations outnumbered the number of consumers discharged from our service. Anecdotally, I have seen this consistently across my eight years of service within the case management team. This does not consider the increase of total population increases of our district either. Since my commencement in 2015, we have seen a total increase of 2 fulltime equivalent (FTE) across the team I work with and were only considered following two serious incidents in which a staff member was seriously wounded, and a staff member was sadly killed. Nevertheless, however the "enhancements" were obtained, they are not in line with persistent increases in demand. We are repeatedly asked by management to discharge people if there is a significant decrease in staffing, or, and increase in

demand – This is in lieu of creating additional FTE. As you expect, this has a great impact on the quality of care provided to consumers. As mentioned, some who are in a better position both psychiatrically and/or socially may be discharged before they are ready, to account for demand. Additionally, there has been a significant increase in the number of consumers provided involuntary community-based treatment, which again is not considered within measurement of service demand. As these consumers are obligated to receive treatment, and we are obligated to provide said treatment, many consumers who are seeking treatment on a voluntary basis and want support are often overlooked to account for this "involuntary demand."

53(iii) (c) – *The work performed by the employee will be able to be satisfactorily completed within the ordinary hours of work assigned to the employee in their roster cycle.*

This is anecdotal evidence, and I can't see a way to quantify it otherwise. In my experience, myself and my colleagues across the case management teams work persistently outside of working hours. Prior to 2020, we were not even entitled to overtime if we worked outside of our "business hours" (my case management team worked 830 – 1700, Mon-Fri). We were told that we should not be working outside of these hours. Despite this, many of us do, to provide a reasonable standard of health care to our consumers. While not occurring often, if a consumer presents in the minutes prior to closing, we are obligated to see them. Additionally, if a person requires transportation to hospital, we must remain with them until such time as their care can be handed over to respective team – This can occur outside our working hours. Again, I reiterate, they prior to 2020 we were not provided financial compensation, and this was done purely out of goodwill, and care for our clientele. Another consideration is the ever-increasing amount of mandatory clinical documentation that either reduces your daily clinical face to face contact, or you remain after hours to complete it.

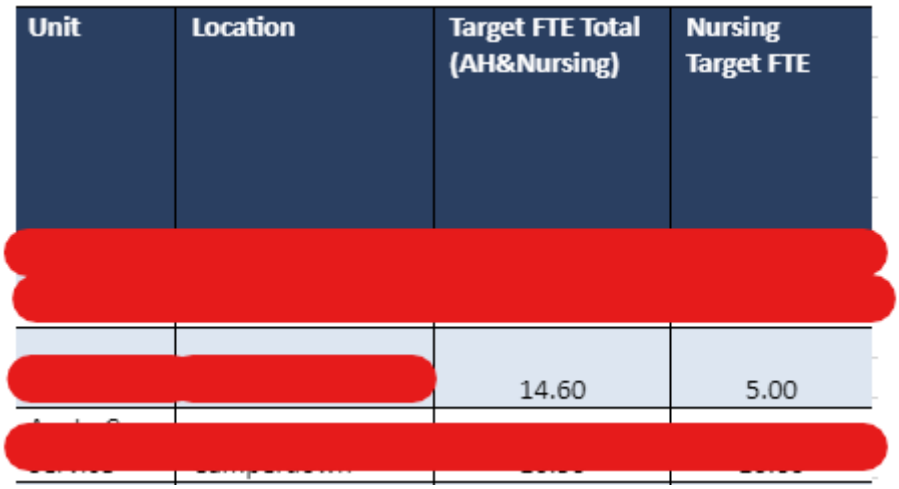
53(iii) (d) – *The work will be consistent with the duties within the employee's classification description and at a professional standard so that the care provided or about to be provided to a patient or client shall be adequate, appropriate, and not adversely affect the rights, health or safety of the patient, client or nurse.*

See above. I am of the opinion that the rights, health and safety of our consumers, and staff are impacted by the lack of staffing, particularly nursing staff.

53(iii) (e) – *The workload expected of an employee will not be unfair or unreasonable having regard to the skills, experience, and classification of the employee for the period in which the workload is allocated.* 53(iii) (f) – *An employee will not be allocated an unreasonable or excessive nursing workload or other responsibilities except in emergency or extraordinary circumstances of an urgent nature.* 53(iii) (i) – *Existing minimum staffing levels to ensure safe system of work and patient safety shall continue to apply.* 53 VII (g) – *Existing appointed positions, e.g. CNCs and managers, must be maintained in their current role, and except in the case of emergencies, shall not be routinely used to cover nursing shortages in the general workload areas. To ensure this occurs, each appointed position should have a position description that defines the scope and requirements of their primary role. Leave relief for these positions is required in the funded FTE.*

I'll address these all-in-one answer. There is a reasonable workloads committee that meets quarterly to my understanding. It is largely targeted at the inpatient setting, and Nursing hours per patient day: Which does not translate to the ambulatory setting. Therefore, there is little support available following recommendations of these committee members. Regarding skill mix and excessive workload, the community mental health setting in my area of practice does not account for leave cover. When

colleagues take annual leave, any expected or unexpected leave, the care of their consumers are covered by existing staff, increasing their workload. It does not take much for several staff to be unavailable, and all care is assumed by existing staff members, with no additional staff sourced to cover leave. This is also the same for staff vacancies, which we see a high level of turnover. In my experience, most community mental health services have persistent vacancies, leading to excessive workload. Little can be done to address skill mix, as we are at the mercy of who is available on any given day. Regarding existing staffing levels (see below).



Unit	Location	Target FTE Total (AH&Nursing)	Nursing Target FTE
[redacted]			
[redacted]		14.60	5.00
[redacted]			

This is snapshot of a document related to nursing FTE targets in my workplace. This is from 2019 and does not account for the increase of 2 nursing FTE. However, they are graded clinical nurse consultant positions, and as will see further below in this document that I would argue they should not be included anyway. Additionally, this does not account for the nursing unit manager of our team either. For the record, I have obviously redacted any identifiable information. This is a broad target, and on paper, we generally meet this expectation most of the time. However, it does not consider the staffing levels of our team daily. Within this document is also a target that nursing staff account for approximately 34% of the total staffing for our team. For context, this FTE target services a fluctuating consumer base of 300 – 450 consumers. I conducted an audit of our roster for the 2022 calendar year, looking at meeting nursing target FTE and total minimum nursing percentage. Averaging the daily FTE to each month, we met the target FTE once over the 12-month period, with the average FTE for the year being 3.8. As mentioned above, this is due to fluctuations in staffing and leave – None of which is covered by additional staff. Moreover, myself as a clinical nurse consultant, my fellow clinical nurse consultant on my team, and my nursing unit manager have been covering unit shortages in perpetuity since our positions were created. The current clinical nurse consultant position I work in was created in 2021, and prior clinical nurse consultant position I worked in prior was created in 2019. Pursuant to 53 VII (g) I have been used to cover nursing shortages for 100% of my employment as a clinical nurse consultant, in fact, locally, it is considered part of my position description to do so.

A great example of this is the current staffing at my workplace. The nursing staff consists of 3 Registered nurses, 2 clinical nurse consultants, and one nursing unit manager. Two of our three registered nurses are presently part time and account for approximately 2.4 FTE, with 1.4 of this FTE not available on Friday's. So, the 2 clinical nurse consultants and nurse unit manage provide an increased level of clinical care every Friday in ad nauseum. This is considered an acceptable level of staffing for a consumer base of 300 – 450 clients. Of those, an estimated 100 consumers require intramuscular injections, which can only be administered by nursing staff. I don't consider this to be adequate.

53 VII (c) – … *Managers are responsible for scheduling annual leave equitably throughout the year to manage leave liabilities and to prevent unreasonable increased workload for remaining employees arising from the taking of leave.* 53 VII (i) - *Community Health Services must have the ability to maintain a "pool" of casual staff to manage unplanned leave and vacancies or a sudden and unanticipated increase in workload.* 53 VII (j) - *Reasonable deployment within individual Community Health Services to address uneven workload distribution should occur as a day-to-day management strategy. However, this should not be seen as a method of covering unfilled vacancies or ongoing sick leave. Long term demographic trends may result in adjustment of boundaries to enable existing staffing to better accommodate the needs of the community while still maintaining composition of their team.*

This is covered by the above, but it is worth noting that managers do their best to manage workload, however, without additional staff covering leave, it is near impossible to prevent unreasonable workload. To reiterate, we are not meeting the expectations outlined in 53 VII (i) & (j) within my workplace, it simply does not occur. A “casual pool” of staff is available, however, they do not provide leave cover. They often cover “additional duties” that fall outside of the case management role, which would require another entire report to address.

53 VII (h) - … *These programs would include a reasonable number of "supernumerary" hours followed by appropriate allocation of patients according to the complexity of need and the new staff’s level of training.*

In my workplace, and the district I work in, case management teams do not provide supernumerary hours to new staff commencing in our workplace. Additionally, allocation of consumers according to new staff’s level of training and the consumer complexity is flagrantly ignored by management.

To summarize, I want to thank you again for you dedication to the people of NSW, and for bringing about this inquiry. I am of the opinion that the community mental health service is not adequate, fit for purpose, has not been scaled in keeping with population growth, and is seeing a higher level of complexity among our consumers. A significant contributor to that is inadequate staffing, particularly nursing staff, who have a unique role within the multidisciplinary team that cannot be replaced. I am more than happy to be contacted further if required.

Kind regards,

Mr Marc Lamond:
Registered Nurse,
NSW resident