

NSW MSEC Submission to the Rural and Remote Health Parliamentary enquiry NSW October 2021

The NSW Medical Staff Executive Council (NSW MSEC) is formed by the Medical Staff Council Chairs of all NSW public hospitals. These are the elected representatives of all senior medical staff employed at NSW Public hospitals. Input for this enquiry has been provided from senior doctors across NSW with decades of experience within the NSW public hospital system.

It is the hope of the NSW MSEC that the current parliamentary enquiry will be able to synthesize all the material it receives and make robust recommendations for comprehensive bipartisan reforms of key areas of the NSW Healthcare system. Providing equitable access to high-quality healthcare for all rural and regional patients requires a **fundamental change in philosophy** in how NSW chooses to structure and deliver healthcare services. It requires a change in the current structures to promote a truly state-wide model, aimed at ensuring equity of access and uniformity of healthcare standards across all LHDs.

The problems that exist in the delivery of regional and rural healthcare have been well documented. The fact that there are problems with staffing, resourcing and health outcomes is well established. The follow through of effective, co-ordinated reforms has been deficient to date. Improvements can be achieved. When large, ambitious, clinical improvement programs are funded and co-ordinated at a state-wide level (eg NSW Regional and rural cardiac catheter lab and state-wide reperfusion strategy for heart attack care by NSW Health and NSW Ambulance) big gains are achieved in the improved access, outcomes and in decreased mortality. However, a greater state-wide focus needs to be applied to a greater number of clinical performance areas with sufficient resources to monitor and implement change across LHDs.

The key to making a difference to rural healthcare delivery will be to focus on delivering high level system and structural reforms in 10 key areas;

1. Re-establishment of State-wide service planning, rather than reliance on a siloed LHD model. In general, rural hubs for almost all services can and should be established and further developed as a metro-centric model is not cost effective. Highly centralised services (for example paediatric intensive care) must have robust systems and resources to ensure equity of access.
2. Reform of independent oversight and governance – as per April 2019 Auditor General’s report recommendations (not fully actioned/implemented)
3. Establishment of avenues for early conflict resolution, independent of the LHDs. In particular, in cases where a Medical Staff Council votes “no confidence” in a hospital and/or LHD administration, an automatic and comprehensive review of that LHD and of the MSC concerns should immediately take place by external agencies (ACI, CEC, NSW Health), with transparent reporting. Senior staff should be supported rather than bullied or harassed when raising important patient safety issues e.g. Broken Hill Hospital
4. Review the role and performance of the LHD Boards. The boards were intended to be an independent oversight body, distanced from the CE. This has not always been the case. The auditor general noted a lack of clarity on what is “operational” and what is “strategic” and noted a need for formal board orientation and education. They reported that some boards see themselves as “Rubber stampers”, which may reflect the reality and deficiency of the current LHD boards as strategic oversight bodies.
5. Fix the poor engagement of Boards with clinicians and poor inclusion of clinicians in decision making more broadly. KPIs are needed to monitor engagement of LHD boards with Clinicians and communities and to monitor involvement of clinicians in service delivery decisions. The Auditor

General report 2019 noted that “engagement has not met the expectations of devolution and requires attention as a priority.”

1. Stop the overspending of public money on consultant reports (\$29 million in 2020) and re-invest this money. By consulting clinicians within the organisation or within the pillars (ACI, CEC), these questions could often be answered, and the money invested in building senior staffing and strategic capacity within the organisation and within the pillars.
2. Take action on the wealth of data generated (e.g. BHI data and People Matters Surveys) to continually improve systems.
3. Address specialist workforce distribution at a state-wide level. The myth that the current deficit in per capita specialists in regional and rural areas is due to specialists not wanting to go rural must be dispelled. Obtaining approval and funding for a new position can take years of lobbying and business cases. Leaving these key workforce distribution decisions solely to the LHD finance processes is a poor system that does not recognise the full impact of the per capita specialist workforce deficit on rural communities in healthcare provision, both in and out of the public hospital setting. The federal/state divide of funding does not help rural communities where specialists need a public hospital (State funded) appointment to make relocation to a regional setting viable. Stability of senior medical staffing is essential in rural areas and different models may apply in different locations.
4. **Ensure stable referral pathways for transfer of regional and rural patients to hub hospitals/metro centres and establish KPIs on waiting times.**
5. Ensure any rural telehealth solutions meet the short, medium and long term needs of regional and rural patients and that they support and communicate with locally based clinicians and do not seek to replace them.

Additional notes on the NSW MSEC opening statement:

The current Local Health District model has been in place since 2012. Under this model centralised planning functions of NSW health (State-wide 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, NSW MSEC 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 their role is and what the role of the LHDs is. 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 fulfil its state-wide 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 **state-wide 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.
 - Devolved model has limited ability to develop major new services
 - Limited ability to achieve uniform service delivery in core services (e.g. treating heart attacks by access to a cath lab 24/7 not routinely available in all LHDs, despite most having the necessary infrastructure)
 - 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 e.g. presence of Clinical Nurse Consultants, number of junior medical officers based on a services’ patient activity level as two examples
 - 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
 - Business cases need to be state level with sufficient financial expertise to identify savings across agencies e.g. building local capacity for regional and rural healthcare services is definitely cost effective when savings in patient transport and wasted bed days 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.
 - The current system is almost completely dependent on self- reporting by the LHDs
 - The CEC, ACI, BHI could have a monitoring and supervision role

- 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
- 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 there is little capacity at the tax office to actually check the contents.
- The Auditor General Report April 2019 stated “There are areas where accountability and oversight can be improved including;
- Continued progress in moving toward patient experience, outcome and quality and safety measures
- Improving the health performance framework document to ensure it is comprehensive, clear and specifies decision makers
- Greater clarity in the nexus between underperformance and escalation decisions, including governance-related performance measures
- More rigour in accountability for non-service activity functions including consumer and community engagement
- 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 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.
- 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.
- A shift to earlier objective assessment, more apologies when things do go wrong, with openly disclosed steps for improvement, would build staff confidence
- 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
- 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**

- Relationship of CE and board chair described as “too cosy” in one case by Auditor’s report
- 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
- The role of Boards can be seen as “rubber stampers”, rather than involved in decision making, for example in the negotiation of service agreements
- 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
- 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
- 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 (IMS+system).
 - The Auditor General’s 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.
 - Routine oversight needs to include additional KPIs. The BHI generates a wealth of performance data. Not all is taken into account in performance frameworks.
 - 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 bed days 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:**
- 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.
 - 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.

- NSW needs to be smarter about removing barriers to allow this shift of specialists workforce to rural hubs to occur
 - 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
 - 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
 - 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.
9. **Telehealth:** Telehealth can be a powerful tool to support patients and clinicians in regional settings
- Poor substitute for locally based clinicians and workforce who can provide ongoing care for patients
 - 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
 - Models must document and hand over care to locally based health care services to provide for the ongoing needs of the patient
 - 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
 - Successful telehealth models need to fundamentally support the on the ground clinical staff and not seek to replace them

https://www.abc.net.au/news/2021-10-05/nsw-gunnedah-lismore-taree-forster-back-in-lockdown/100512536?utm_campaign=abc_news_web&utm_content=link&utm_medium=content_shared&utm_source=abc_news_web

Funding shortage for specialist doctors



The NSW Medical Staff Executive Council said there were major understaffing problems in regional areas.
(Tim Boyle, file photo: Getty Images)

A state parliamentary inquiry is set to be told a lack of funding is a key reason why there are fewer specialists practising in rural and regional NSW.

Nine witnesses are due to give evidence before an Upper House committee that is holding its tenth hearing into challenges accessing medical services outside metropolitan Sydney.

Ruth Arnold from the NSW Medical Staff Executive Council said it was a myth that specialists do not want to work in the bush.

"In many cases there's no funding for a position and to establish a new specialist position can take years of business cases and lobbying," Dr Arnold said.

"So this system really needs to change because there's no question that there's a major per capita understaffing of specialists in rural and regional areas."

Doctors versus managers

The parliamentary inquiry's 10th hearing also heard from the NSW Medical Staff Executive Council, which represents doctors working in public hospitals.



Orange-based cardiologist Ruth Arnold (third from right) wants to see better use of funding. (Supplied: Western NSW Local Health District)

The rural co-chair, Doctor Ruth Arnold, said there was a disconnect between staff and management which could sometimes exacerbate any tensions and conflict.

"There is a tendency for staff to raise concerns, administrators to defend their position because they don't want to admit that they're wrong or that there is blame ... that situation needs to be diffused so that the focus can be on patient care and quality," Dr Arnold said.

Dr Arnold practises as a cardiologist at Orange in the state's central west and told the inquiry that funding was not being used effectively.

She said that NSW Health has spent more than \$100 million on transferring patients and a lot of that money could be saved if the services were available closer to home.

"There's been cases whereby the infrastructure has been present but the commissioning of it and the ability to staff and run it has lagged a number of years behind the provision of the infrastructure," the inquiry heard.

"Most of the rural cath labs (catheterisation laboratories) are not permitted to run 24-7, so you have patients who have got a cath lab in their local health district but it doesn't run after hours, so they're still transferred out of area and that's not good for patient care."

The inquiry continues.