22

SUBMISSION TO THE PARLIAMENTARY INQUIRY INTO THE ACUTE HEALTH SYSTEM

Dear Committee,

I worked for the Tasmanian Health Service in its many iterations, from 1994 until 2017. From 2005 until April 2017 I was the Podiatry Manager responsible for Podiatry and Footcare services to and directly interfacing with the RHH and Repatriation General Hospital. This included outpatient services from the Telstra centre, and community podiatry clinics in health centres across the southern region.

As a manager of an allied health profession, I was a member of the Allied Health Professional Leadership Advisory Committee, which was a decision-making body, equivalent to both the Medical and Nursing Leadership Advisory Committees, which had reporting responsibilities through the Director to the Executive(s) over the years. RHH/THS executive would also brief the committee, for example when there were reductions to allied health professional department full-time equivalent numbers targets to be met. This was the RHH hospital executive until 2015 when the statewide executive was formed.

I am also an alderman on Hobart City Council and have interactions with many people who are directly effected by the RHH as workers or users of the health system. As a city leader, I recognise the importance of a well-functioning hospital and healthcare system not only for good health but as an important economic driver as the city's biggest employer.

I do hope that this submission and any presentation to your committee will be of benefit for improvements to the acute health services.

(1) Current and projected state demand for acute health services.

Demands for Podiatry services at the RHH and RGH hospitals are likely to increase until such time as a sustainable model for clinical staff, specialists, nurses and allied health professionals can be instigated in both the north and north-west of the state. There has been an obvious failure to do so, with professional isolation, burnout and reputational risk for some of these services. Not being able to attract specialists such as neurologists, vascular surgeons, endocrinologists flows on to podiatrists and other allied health professional services, for timely review, referral or even admission to hospital for complications of diseases podiatrists treat.

For podiatry and particularly those people who need to attend the High Risk Foot Clinic (HRFC), there is a demand from the north-west and northern regions because of a lack of access to adequate, or any, endocrinology and other specialists. This means that the southern HRFC has set up a Telehealth service for the northwest Diabetes Centre, at the insistence of the Minister, which is known to be time intensive and with limited long-term benefits. Two southern-based podiatry High Risk Foot Clinic patients per fortnight (48 occasions of service per year) cannot be seen because no additional resources have been provided for this clinic. The southern endocrinologist has no separate time to see these clients but must see them in

the allocated High Risk Foot clinical time. Also, sometimes because of co-morbidities, patients from other parts of the state may need to be seen by podiatrists in the south as inpatients, which creates more demand for what is already at over-capacity, where demand on services outstrips ability to provide care. Of course, this is the nature of a statewide hospital but I had raised concerns about the impact of providing a Telehealth service to the north-west that cut directly the capacity of a clinic that runs to capacity through very good management by the Specialist Podiatrist clinic coordinator.

The High Risk Foot Clinic and podiatry ulcer and emergency clinics serves a really important role in keeping people with compromised foot health out of hospital. But lack of spending in this area to meet burgeoning demand has an erosive effect on staff morale, and needs to be better funded to keep people well in their communities.

(2) Factors impacting on the capacity of each hospital to meet the current and projected demand in the provision of health care services

One of the gravest concerns is the status of the RHH as a teaching hospital. The RHH is a training institution not only for medical and nursing, but also for placements of interstate Allied Health professional students. Podiatry has a strong reputation as an excellent placement for undergraduates from many of the interstate universities which offer podiatry. The recent withdrawal of psychiatry training at the Royal Hobart Hospital is an absolute blow and should be reversed immediately. The reputation of the RHH is damaged and this could have flow-on effects to other disciplines, professions and would be very damaging if the status of the Medical School and the RHH as a training hospital was brought into question.

Demands for Podiatry are likely to increase. With increased ageing and more people with diabetes and end-stage complications which podiatrists treat - e.g. Diabetic foot ulcers, post-surgical amputations - there is a corresponding need for podiatrists delivering inpatient care. Correspondingly, cuts to frontline allied healthcare providers including podiatrists in 2014, and a failure to respond to subsequent numerous requests for increased primary health podiatry services has led to greater waiting times between appointments, increased likelihood of complications which makes some vulnerable clients more likely to need greater intervention.

(5) The impact, extent of and factors contributing to adverse patient outcomes in the deliver of acute health services.

I had a very cohesive and loyal Department of just under twenty people whose main clinical function was delivering health services to inpatients, outpatients at the Telstra building, and in various community health centres in metropolitan Hobart and rural southern Tasmania.

Like many people working in health, I have enjoyed and found my career both rewarding and purposeful. However, one of the most compelling reasons that I left the health service was because of an obvious decline over the past 2-3 years: there is a lack of spending and the downgrading of health services and the bureaucracy is failing. There is considerable wastage of funds, human resources, diminished respect for staff.

There is a culture of resistance from senior management to recognise problems and act swiftly when issues are raised. An example was of a security system in the Telstra building where podiatry and other services coexist. For example, it took 3-4 years for management to finally instal a system, despite it being raised by myself and other managers as a concern for the safety of both clients and staff. This is one example of staff feeling undervalued because their concerns took so long to be addressed.

Sadly, right now there is by far the lowest level of staff morale I have seen over 23 years in the Tasmanian health service. With people leaving because of dissatisfaction, significant skills and corporate knowledge is lost. There is also fewer people remaining in their chosen professions, because of stressful work environments.

All of these collectively manifest themselves as direct or indirect impacts on patient care, including inpatients, day patients, outpatients, those using diagnostic services, and community clients.

By the time David Alcorn arrived as CEO in 2015, many senior executive staff were relocated from Hobart to Launceston to run out of the Northern integrated Care Centre. I believe that this restructure to a statewide system and the way it has been implemented has been not only a very expensive and wasteful exercise (time, travel, petrol, financial cost), but that it had an extremely negative impact on the running of the RHH, the chain of command, roles and responsibilities and clear decision-making for the hospital. I am of the very strong view that without a CEO of the RHH and executive, the RHH was severely weakened as a functioning institution. Over 3000 people working at the RHH and no CEO obviously has ramifications for service care and delivery, with often poor or no decisions that made it difficult to effectively run the hospital.

Importantly, with the senior executives' relocation to Launceston, I found that there was a significant disconnection between staff and the THS executive. The CEO rarely visited Hobart to engage with staff. Over his two years as CEO, he has had very few public forums with southern staff and managers, and often these were hastily called and at times that did not really allow a cross-section of workers to attend, including operational members of staff such as cleaners. Often he appeared quite rude towards senior clinicians.

On one occasion earlier this year, I attended what was a hastily convened meeting after Dr Alcorn met with doctors in the morning when he came to Hobart. It seemed as an afterthought that there was an afternoon meeting with nurse managers and allied health managers. At that meeting it was clear that the senior nurses who numbered about 8 were very tired, their faces drawn - I have worked with them over many years and had never seen them looking so dispirited, frankly. Only two Allied Health managers could make the meeting with such short notice. Members of the exec who attended were talking about mortality rates, and there was clearly a dispute with at least one nurse manager about how these statistics were interpreted - she believed that they were being misinterpreted and therefore underreported. There was a display of obfuscation by the executive who were present, which I found troubling on what was such an important subject.

There was also a disclosure at the meeting by one senior nurse about the culture of new nurses who during recruitment were talking about the culture of intimidation on some wards where they'd been placed as students, and they were not looking forward to starting their careers in such an environment. She also stated that the new hospital K Block building will

not be of any use if there is no change in this culture of bullying. I am unsure whether any of that was followed up by the executive and Dr Alcorn. Obviously this has significant impacts for care of patients and recruitment and retention of staff.

I also question the appointment of some senior Executives at this changeover period and their effectiveness at that critical time who appeared out of their depth. There was little clear direction nor involvement in decision-making for senior clinical staff - medical, nursing and allied health, as well as other service staff to be consulted and engaged in decisions for the effective running of the hospital. I believe that there is evidence to suggest that this has reduced the effective functioning of the RHH and THS services in the south, ultimately having an impact on the acute health systems' delivery of health services.

Poor planning during the B Block demolition, where the number of beds were reduced and then had to be reinstated at the cost and disruption to other areas, poor patient flow management, early discharge. I know that this was very disruptive for ward staff, but also podiatrists covering inpatients, who rely on the smooth running of the ward to make their short available time as effective as possible.

Coinciding with Dr Alcorn's appointment, there is a pervading culture of cover-up and a lack of response to needs of staff. Waitlists were introduced to areas to manage ever-increasing numbers of people not being able to access care, and the escalation plan announcements became a frequent occurrence. They were introduced in parallel with the escalation systems announced over the hospitals' loud speaker almost daily to identify that there are bed blocks, and a need to discharge patients early from hospital. The problem is that discharge before podiatrists can see patients may mean that their likelihood of readmission or worse health outcomes is predictably high.

There were times when I covered the position of Allied Health Director (part of the southern executive which still existed at the time). Once was in 2014, soon after significant rationalization of Allied Health professional staff especially in the south of the state was occurring. Allied Health disciplines were asked to reduce their full-time equivalent, despite what the Minister was saying at the time, which had an impact not only on the acute health services, but frontline positions in community centres and outpatients meant that there were allied health professional positions that were absorbed, or left vacant to meet those targets. This in turn had an effect on timeliness of services, the number of treatment you can expect in the hospital, or as an outpatient whether patients would have follow up appointments in the time required.

Whilst in that role, I met with senior clinical managers from another profession I had responsibility for, who provided care at the RHH who were deeply concerned about recent staff cuts to their service which was severely effecting their ability to deliver safe, timely care to their inpatients, and the impact on staffing - burnout, retention of senior and skilled clinicians, being able to supervise students and junior staff, recruitment and sustainability. They requested an increase in staffing which I lobbied for and the clinical position was reinstated. It was evident that this was the first time that these managers had been heard by someone in the position I was covering for. They were very concerned about the cuts to Allied Health Professional staff numbers that had severely compromised their professionalism.

This lack of perceived and actual support displays a lack of genuine input, a disrespect for clinical managers and their clinical staff, and disconnection between the hospital leadership team and other staff who deliver care. It was important that they spoke up at the time, but there is not always the culture to do so in the THS, nor is it necessarily the culture of Allied Health Professionals to necessarily speak out either. This could improve if there were better connections and less managing up, and instead advocating for staff.

Waitlists were introduced to manage Podiatry outpatient demands, and clinics to community centres had to be cut to community health centres. Effectively it meant that many people were turned away from entering care, or for follow up appointments to see the podiatrists. Whilst re-modeling the delivery of healthcare services should be a continual process in order to do things better, this was extraordinary, given Tasmania's increasing rates of illness, especially for Podiatry in the area of chronic diseases such as diabetes, and our fast-ageing population.

Services to inpatients require coordination of care and systems to support that to be effective. Currently there is a reduction in capacity to deliver adequate care. Podiatry inpatient services referrals have been increasing yearly because of greater complexity in the cases. Podiatry services are very limited to the hospital with 2 mornings per week allocated - most podiatry work is done to prevent hospitalization. Despite business cases asking for greater podiatry staff to meet this ever-increasing demand, there was no success in employing more staff for hospital care.

Given the restrictions, and the very short length of stay for inpatients, it is not always possible to see inpatients before their discharge. The worst cases are prioritized, but sometimes there are many "worst" (priority 1) cases, and it is not possible to see all. Quite often, the patients if they go home early with a foot wound or poor mobility and peripheral neuropathy causing difficulty with walking and risk of falling, podiatry high risk Foot patients are re-admitted as inpatients.

The only time recently that the podiatry service secured part of a position was when there was a likelihood of the High Risk Foot Clinic ceasing to operate at its maximum, and we had the endocrinologist argue the case and a casual (more expensive employment option) Podiatrist was/is still engaged.

When there is a long wait between appointments for clients who require regular care because of complication of diabetes, they will often be seen in the Podiatry emergency clinics. For those whose ulcers are causing systemic infection (e.g. Cellulitis), they often require antibiotics and sometimes will need to be admitted. This is often through Emergency Department of the RHH, although some high risk outpatients are privately insured, but it is unlikely that private hospitals will treat them. Most would end up as inpatients. Some require amputation. Which has a longer recommended stay in hospital than the average length of stay.

Keeping people mobile and well in their communities is the goal. One intervention the podiatry service introduced recently was contact casting and figures done on this suggest that there is a cost saving of approximately $10000 if a hospitalization is avoided. To the patient there is a marked quality of life when avoiding hospital admission. Podiatry staff undertaking the trial work closely with the plaster technicians in making contact casts. It takes time but is cost-saving in many cases.

Investing in employing healthcare workers is a sure way to bring down the burden on the acute health system in southern Tasmania.

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