GOVERNMENT OF WESTERN AUSTRALIA

Sustainable Health Review

Public Submission Cover Sheet

Please complete this sheet and submit with any attachments to the Sustainable Health Review Secretariat

Your Personal Details ***This information will be used only for contacting you in relation to this submission***	
Title	Mr ☒ Miss ☐ Mrs ☐ Ms ☐ Dr ☐ Other ☐
Organisation	Health Services Union of WA
First Name(s)	Dan
Surname	Hill
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Publication of Submissions

Please note all Public Submissions will be published unless otherwise selected below

☐ I do not want my submission published

☐ I would like my submission to be published but remain anonymous

Submission Guidance

You are encouraged to address the following question:

In the context of the Sustainable Health Review Terms of Reference listed below, what is needed to develop a more sustainable, patient centred health system in WA?

- Leveraging existing investment in Primary, Secondary and Tertiary healthcare, as well as new initiatives to improve patient centred service delivery, pathways and transition;
- The mix of services provided across the system, including gaps in service provision, sub-acute, step-down, community and other out-of-hospital services across WA to deliver care in the most appropriate setting and to maximise health outcomes and value to the public;
- Ways to encourage and drive digital innovation, the use of new technology, research and data to support patient centred care and improved performance;
- Opportunities to drive partnerships across sectors and all levels of government to reduce duplication and to deliver integrated and coordinated care;
- Ways to drive improvements in safety and quality for patients, value and financial sustainability, including cost drivers, allocative and technical efficiencies;
- The key enablers of new efficiencies and change, including, research, productivity, teaching and training, culture, leadership development, procurement and improved performance monitoring;
- Any further opportunities concerning patient centred service delivery and the sustainability of the WA health system.

hsuwa
with you at work

Our Ref.: DH:DH HO.204.17

Ms Robyn Kruk, AM
Chair, Sustainable Health Review Panel

By email: SHR@health.wa.gov.au

27th October 2017

Dear Ms Kruk

RE: Sustainable Health Review – Health Services Union of WA (HSUWA) Submission

Thank you for the opportunity to make a submission to the Sustainable Health Review (SHR).

The HSUWA is the trade union that represents more than 16,000 people employed in WA's public hospitals and health services. This is a significant proportion of the 34,336 full time equivalent positions employed directly by Health Service Providers and funded for 2017-18 (Source: *State Budget Paper No.2 – Volume 1 Part 4*). Members are employed as, for example administrative staff, clerks, health technicians, physiotherapists, pharmacists, medical imaging technologists, clinical psychologists, social workers, medical scientists, speech pathologists, occupational therapists, dieticians, podiatrists, mental health workers, and other health professionals. All play a vital role in providing and / or supporting clinical services in WA's public hospitals and health services. The HSUWA also have coverage of the same callings in the non-government health sector, aged care, and disability services.

The HSUWA has appreciated the consultative processes that are underway including the meeting held with yourself in the early stages of the Review. Whilst the Union has encouraged our members to participate in the Public Forums where possible (difficult given they have in the main been held during working hours) and to respond to the call for public submissions, we are concerned at the lack of direct staff engagement to date. Feedback from members reveals limited knowledge of the SHR and understanding of the implications for them. This is despite the level of detail posted on the SHR website and global messages from the Director General.

The Union believes it is vital that the health workforce generally be engaged in the SHR and suggest that this should be addressed by the SHR Panel as soon as possible. The recent establishment of the Workforce and Culture Working Group may address this in part but more needs to be done.

We have previously raised questions regarding the interrelationship between the SHR and the Service Priority Review (SPR) that is due to report by 30 October 2017. We note that the SHR is required to consider how best to implement any Government endorsed recommendations arising from the SPR (*ToR Role and Functions No.7*). A number of the themes of the SPR are directly relevant to the SHR and we have included as part of this submission the responses received from our members to those themes as they relate to health. See Attachment A.

The SPR issued an interim report in August and the Union's submitted feedback is also attached for the consideration of the SHR panel (see Attachment B). This also included a specific proposal for interpreting and translation services.

Attachment C is drawn from a survey of our public-sector members. Over 640 members responded to the survey, from across the State and each of the health services. Responses from the survey have provided an overview of how members feel about the current state of public health system. Members feedback indicates that recent changes in the health system have compromised patient care and that waitlists have become longer. Nearly 80% of members reported an increased workload, with almost half of that number reporting the increase in workload to be significant.

Further, the top three workplace issues for members are security of employment, reasonable workloads, and salary and benefits. These results reflect conversations we have had with members during 2017, people are feeling squeezed and anxious about the future.

In concluding, the HSUWA looks forward to continued contribution to the Sustainable Health Review processes and remains available to discuss with the Panel any matters arising from this submission.

Yours Faithfully

Dan Hill
Secretary

From a regional health perspective it has been interesting to watch over the last 5 – 6 years how the FTE and funding in the regions is constantly being reduced to provide funding for FTE at WA Country Health Service - Central Office.

If one was to review an FTE report from 2012 to 2017 identifying the FTE across the WACHS sites, I would be interested to see the change in FTE and where the jobs in WA Country Health Services are being located.

WACHS Central has the highest FTE across WACHS sites – there are no patients at WACHS Central.

Positons and funding are constantly being taken away from the regions for positions in central office, often around the perception of improved governance etc, the fact is that many of the jobs in Central Office could be undertaken in the regions.

The constant battle between clinical and non clinical duties and positions exists however there are non clinical duties that clinicians shouldn't or don't wish to perform.

The waste in health is phenomenal, there is potential to improve this situation however sometimes clinical and infection control standards eliminate the potential to improve the situation. For example, sterile scissors have a finite life and if not used within their expiry date they must be disposed of, they cannot be sent overseas, they cannot even be sent to the vets.

My comments are regarding Theme 3 (Efficient and Effective Systems and Processes) – specifically "How could the public sector be better organised to operate more efficiently?"

I believe that the public sector could be better organised by managing staff more effectively; namely to reduce the amount of staff hired on a fixed-term contract basis. I am one such staff member who has been at my current job for almost 5 years on continuous fixed-term contracts. I am an active member of the team who regularly contributes to our KPIs, vision and projects. While I do work with an excellent team led by a wonderful manager who values my place and input, I do feel limited with my own scope in this team and almost have a sense of being "on the outside, looking in". It is not a very nice feeling and engenders fear and insecurity. I've had to seek employment at another public hospital to ensure a little more security (although this is also on a fixed-term contract basis).

At work I always work to my full capacity – however I feel I that our organisation would benefit from more permanent staff and less contracts to improve efficiency. This is my number one priority which I would like to see addressed by the State Government – job security.

How can the public sector foster a high performing workforce that meets both government goals and community needs?

Make sure your employees are happy, value them and provide support on a long term basis, so they can be the best version of themselves.

Make WA Health the best employer, so we are known to be a really good employer and people strive to work with us.

Work continuously on Employee's health and wellbeing and do not get complacent about it. Take stress or mental issues at work serious and educate your Supervisors / Managers & Executives about it. Existing bullying awareness programs are not sufficient.

Performance Management for everyone and a fair go to anyone, that is the believe and feeling that all employees have to feel, to see that the system is fair in its core. At this stage, it isn't. PDS for all levels staff, no matter the seniority. Real accountability for all.

We have to deal also with the issue of pockets of inconsistency through the new HSP model, where the policies and more so the daily practise can differ from site to site. There needs to be a possibility to all staff to report such inconsistencies across to the System Manager or third party.

Other safe and secure reporting tools need to be implemented as well, to be in particular outside of the system, the system that could be the issue and cannot be the solution.

The professional skills of our leaders should be questionable/reviewed and checked against performance measures if they are still fit for purpose. The current system does not account for review of our leaders skills and if they fit into the landscape the leaders have to manage and lead in.

How can senior officers be better supported to manage their teams more effectively?

With leadership, good leadership.

How can public sector agencies work together to better share and exchange workers' knowledge and expertise?

Provide a culture and a system around sharing and exchange. Yammer will not suffice for that, as it will need an internal push of need, which means we will need to have an open forum on culture. Asking difficult questions should be encouraged and while asking the "7 Why's?" to find out why we do not have such a sharing and exchanging culture as a start. Create an information and knowledge sharing culture, promote that culture, build a cross team and give a mandate and resourcing to find and implement a solution to achieve that goal.

In what ways can the public sector draw on the knowledge and expertise of the private sector?

The privatisation issue still is on the table. While that issue is on people's minds as is mostly seen as a threat and the Government has not removed it from the table, no real effective ground on working together with private sector can be achieved.

What new technologies could be used to achieve better service outcomes?

We need a Health-wide App Portal, which provides all the essential applications to staff to make services for all WA Health employees mobile and accessible. "A Health-Wide Intranet for Apps".

From there we can start looking deeper into the "Existing Apps" and "Core Needed Apps" and also into more specialised "Needs for APPS" as an example per workforce area like the JMO's and tailor to their real needs to enable them to manage their own and others' (med workforce) work better.

Provide a mandate and resourcing to build a cross team to deliver a Health-Wide APP platform and tailor Applications around the need of individuals or groups.

Introduce process mapping initiatives for workforce management (Leave Management), to later create workflows that do reflect the Business Processes of people or a groups.

All of this will need to be available all the time, on mobile devices or tablets or desktops and connectivity is provided as an always on approach, so Internet connected. Security is managed by ICT and all measures are implemented for security of information and data.

Educational institutions have gained very satisfactory results in having successfully introduced a Laptop per student policy.

A Tablet/Laptop per Doctor/Nurse/Health Professional etc could be something WA Health could investigate.

If the business rules are mapped accordingly, creating the workflow and application around it is the easy part.

Theme 2 – contemporary, adaptable and high-performing workforce

As an older worker with less than 10 years before retirement age, I'm finding there are almost no opportunities for career advancement or even upskilling/training, even though we have a vast wealth of corporate knowledge and skills.

There needs to be a more proactive approach in using staff like me as mentors and trainers, rather than sidelining us because we don't have some of the technological knowhow as well as the perception that we won't be around for long.

It's my belief that there is a huge waste of the public purse, regarding the design and implementation of the building works within the Health Department.

Putting the department of treasury in charge of overseeing the costs of new builds has been a disaster, you just have to look at the blow out costs over and above the original estimates for the projects in the first place.

When you had a Department of Housing and Works the plans would be complete from top to bottom, the build was designed and suited to be a hospital everything was listed in the scope of works that was required to be run and fitted out in every area required, making it easy to quote on if you were the builder or contractor, in this way there should be little or no variations to the original costings.

Also building inspectors would oversee the project as it progressed and put right any mistakes and make sure the quality control was adhered too.

What we have now days are architects wanting to win design awards, and the buildings representing and looking more like high class hotels rather than hospitals.

Instead of a full scope of works and every detail being listed for mechanical services etc., contractors are invited to tender and tell them what is required to be used in some instances, and as this of course is very time consuming and as you may not get the job anyway some just walk away or don't bother to tender.

The end result in my opinion is that you end up with a new building that is going to cost more to maintain than the one you have demolished in the first place, and this is a terrible waste of our tax payers money, now take for example the new Perth Children's Hospital it cost a million dollars just to clean the windows and this will increase every year.

The question is why is the government allowing this to happen? Shouldn't these new builds been more cost efficient regarding the heating and cooling (why are they all glass from top to bottom) solar energy and grey water recycling tanks should have been incorporated into the designs.

Self-cleaning glass, or reversible swivel windows for easy cleaning should have been built into the design to save on maintenance costs.

My prediction is that the maintenance costs for these new builds is going to skyrocket out of hand, and the money will just not be there to maintain them, leaving them to deteriorate a lot quicker than they should have done if a proper self-controlled design had taken place in the first instance.

Theme 2

A measure of job security – with employees being given work contracts beyond 'casual' .

High performing workforce needs to be acknowledged and encouraged. Sometimes it helps if encouragement comes directly from Senior Management to individuals rather than a group recommendation.

Senior officers need to have training and maybe encouraged to find ways to expand in effective management of teams.

Currently there is no combined forum for agencies to meet together. A combined government agencies meeting needs to take place either on a monthly or two-monthly basis to look at such things as sharing or resources, partnerships, barriers to service delivery, etc.

Increasing the diversity within the workforce isn't hard – but it is hard to retain workers if positions are 'fixed term' or 'casual'.

Housing support is encouraged for a sustainable workforce in the regions. Currently no housing assistance is available for workers who may be recruited locally – whereas those who come in from other areas are able to access government housing and/or rent assistance. In the long run, it is the local workforce who keeps the workforce stable in a regional community, and this needs to be appreciated and encouraged.

First and foremost I find the inferences and implications of the questions within the themes, particularly themes 2 & 3, to be offensive, as the not so veiled message is that heath workers are not already efficient, accountable or achieving good service outcomes.

I constantly have feedback from patients who tell me that I do achieve very good outcomes for them. My line manager at Fiona Stanley Hospital would not have any idea about my achieved outcomes, as that person is not of my own profession. So, the public sector could be more accountable for service delivery if each professional were to be line managed by someone of their own profession, and achieving that would not cost more! How can accountability be sustained at all, when social workers are managed by physiotherapists, or speech pathologists by occupational therapists?? The FSH allied health leadership model was foisted from above onto clinical staff. Dismantling this model, as I hope will happen, would allow for far improved clinical practice accountability.

Better accountability would be achieved if managers/executive staff were to remain for longer than 5 minutes in their respective positions.. I am heartily sick and tired of global email messages which tell of the incessant movements of executive managers from one position to another. The effect of this, is that very few managers hold an overall, chronological long term knowledge of any explicit service area. Thus no manager retains personal knowledge of the impact of their decisions after they have moved on, or indeed knows sufficiently what has gone before, to be taken into account when making far reaching decisions. There is nothing which can replace the depth of knowledge and practice wisdom which is acquired over years of working in the same position, as many of us do at the clinical level. Sadly the same cannot be said at management and executive levels. Can we please have greater staff stability at higher levels?

I am already part of a "high performing workforce" thank you very much, and I already meet government goals and community needs. I work longer hours than I am paid to do, because I am committed to high performance and quality outcomes. I collaborate daily with community based staff from external organisations which are relevant to my own clinical area, and I receive positive feedback from external organisations' staff regarding my work outcomes.

The private sector has a reputation of actually rewarding and recognising staff achievements and outcomes. The public sector can draw on private sector knowledge and expertise by doing the same, instead of devaluing hard work by presenting the existing themes and questions which clearly infer that we are an inefficient workforce.

Perhaps we could be better organised to operate more efficiently if there were greater stability at executive levels, as I have already said.

As a clinician, I work within a code of ethics and accredited standards which are inherently embedded within my standard practice. All managers should hold prerequisite academic qualifications in management such as an MBA or management diploma. Managerial salaries are high and yet there is no consistent required management qualification. Staff who do not challenge the government's party line seem to simply rise speedily through the ranks, on occasion with scant clinical experience to draw upon, let alone proven managerial experience and qualifications. Let us turn the review microscope to look more closely at those who draw the highest salaries, instead of making scape goats of the rest of us. What about value for money at the higher levels?

Customer-focused and outcomes-based service design and delivery:

In my 28 years with health in my view the most efficient form of management was via the regional health boards eg Vasse-Leeuwin Health Board. Such Boards comprised local appointed community representatives who were familiar with the local region and were accessible and knowledgeable of local conditions and health anomalies. The present "one size fits all" would appear to have issues when attempting to correlate health to the climate, culture, distance, population, diversity and industry in the north of Western Australia to that in the South.

Whilst Teleheath and IT may enable better health advice, it is difficult to understand how data can effectively illustrate health/staff issues when such is rolled up to one WACHS-wide report, and what may be of concern in the north may not have the same need or priority in the southern part of Western Australia.

Contemporary, adaptable and high performing workforce:

The present "revolving door" on management of staffing in my view has a detrimental effect – both on employees and consumers. It is often difficult to determine "who's who and in charge of what " of workers. Rotating line managers; nursing rosters; part-time staff; short-term contracts and staff accrued days off impact on the day to day operation of a unit/hospital - especially when line managers are clinical and not replaced when on leave, ADOs etc. Re-introduction of Hospital Administration Managers would address this issue and enable clinical personnel to do their job – caring for the patient rather than being overwhelmed with non-clinical duties.

It was difficult as a consumer for my husband to understand this continual revolving door of care staff at Fiona and Fremantle hospitals. Whilst "nursing handover" should have provided adequate information as to care needs, difficulty in understanding the english language by some staff, coupled with rarely having the same staff member rostered for more than one shift, did not provide a seamless continuity of care (with the exception of the Physiotherapists). Medication errors did occur and it was only that family was at the bedside that such was identified. Continuity of the same staff – whether clinical, support services or administration – enables a better knowledge of a patient's needs and retainment of staff at the coalface is a priority.

Serco staff at Fiona did not assist in opening food packets and for a patient with semi paralysis in his hands from the Guillain Barre Syndrome it was left to the family (myself and my husband's daughter who flew in from Dubai and we played "musical chairs" for 6 weeks being at the hospital from 8.00am to 7.00pm daily) to assist with patient care. Hospital employed staff did assist with daily needs but were often frustrated when outsourced items eg linen and towels did not arrive, thus impacting on their care timelines. Additionally it surprised me that Serco transport vans sat idle at Fiona Hospital whilst Fremantle Hospital had to rely on St. John ambulance transport for appointments back at their "sister hospital - Fiona Stanley – a costly exercise in time and dollars.

Health is a 24/7 industry dealing with people's lives, and outsourcing vital day to day services hinders the whole operation of the health system. Occupational health and safety in Serco's supply system with staff trying to manoeuvre overloaded and overheight trolleys was not a good sight.

The concept of being a "care team" therefore cannot be overstated. It does not matter whether the employee is clinical, administration, support services, maintenance etc – all should come under a Hospital Administration Manager who manages the hospital/ward; is available to all staff; is not involved in clinical care; is replaced when on annual, long service or personal leave and "captains" all employees into a team rather than individual professionals being isolated in various silos of health care.

The many layers of management in the health system continually grows whilst employees at the coalface decline. A regional director cannot approve policy – such has to be approved by WACHS Perth and one wonders why such duplication of structure. Country management was centralised in Perth back in the late 1980s – then decentralised – in the southwest to Bunbury – then to Albany – then to Vasse Leeuwin Health Board for Busselton, Marg. River and Augusta – then regionalised to SW Area Health Service then to WACHS-SW then for a 6 mth period the south west became Southern Country Health Service then WACHS-SW again and now back to WACHS Perth ie a change every 4 years in name and structure. Such – in my view – does little to enthuse a workforce.

Efficient and effective systems and processes:

IT is an integral component in today's world – yet in health many IT systems in regional areas do not interact with each other as the systems have grown bit by bit as funding permitted and licenses renewed. Such inefficiency is time consuming and can results in inaccuracies in data collection and reporting. Additionally sectors of the workforce are also not computer literate. Whilst administration/ clerical staff have been reduced over the years with the expectation clinical staff will absorb such work, such is not practical when saving lives is the clinical priority. Such change creates stress to staff. For health to operate more effectively requires "horses for courses" – clinical staff save lives; administration staff complete the documentation, reporting, overall management of a health service in adherence to government health policy.

Theme 2: Reshaping and strengthening the public sector workforce.

What can current and future employees expect from participating in the WA public sector workforce?

- Currently a lot of stress, disillusionment and low morale due to lack of permanency, absence of transparency in management positions, use of coercion and duress to perform tasks which compromise clinical and ethical standards.
- Unacceptable clinical demands and caseloads compromising safe and effective clinical service provision.
- Unacceptable requests to dilute clinical practice and professional standards to meet management demands.
- Continuous threats to cut clinical FTE and front line clinical positions, without a commensurate reduction in clinical work. Consequently clinicians are working extended hours with no flexi time / RDO etc
- Autocratic decision making with no opportunity organisationally to raise concerns around safe practice or staff morale. Raising concerns is considered speaking out of line and likely to be threatened with misconduct. Attempts to escalate matters to Risk Registers are thwarted.
- No KPI's around when management would address concerns raised by clinical staff, with accountability only operating from clinical to management level but not in the opposite direction.
- Be part of a culture of acquiescence.
- Numerous positions are being filled by "tap on the shoulder" initially for a 6 month period, but then on rolling 6 month contracts under the premise that recruitment is under way, but this has been occurring in most instances for 18 months+ at times. No intention for appropriate recruitment to occur.
- Often positions at management levels have no EOI or an initial 6 month EOI which leads to the positions being then filled indefinitely, without a competitive recruitment process.

- Known clinicians and managers are promoted at multiple levels.
- Dissemination of professional structure within allied health, with operational managers with no professional or operational experience being appointed and promoted despite substandard performance

How can the public sector foster a high performing workforce that meets both government goals and community needs? –

- Merit based assessment and employment
- Commitment to minimum terms by senior executives in crucial leadership roles. Having changes every 6 months or so at the highest level cause ripple effect all the way through executive, senior management and middle management, results in hasty and temporary appointments and a complete lack of drive and follow-through due to staff only in acting roles or having to learn the ropes for a good portion of their tenure.
- Provides no security and direction and leadership or confidence in the workforce.
- Employ people with acceptable skill and experience. How can you get to executive level without proof of relevant qualification (higher degree or relevant qualification) or demonstrated experience at executive level?
- Recognition of the staffing levels required to deliver services; reaction to budget cuts and constant threat or realisation of frontline cuts.
- Commitment to establish appropriate professional leadership positions for Allied Health, commensurate to Medical and Nursing. Professional groups require due clinical and professional coordination, governance and supervision. This cannot be offered by generic operational managers.
- Invest in senior staff, ensure there are research and education officers/ leaders to support workforce.
- Demonstrate respect for staff by allowing flexibility in work practice eg part-time, mothers/fathers to work school hours, access leave without difficult and complex negotiations.
- Appoint leaders who are committed to performance manage and let go of poor performers or people who breach codes of practice.
- Stop protecting higher level managers who breach policies and procedures and public sector standards by moving them across the health service.
- Redeployee management is problematic. Services have to take staff form anywhere that are not best candidate for role or right fit for team and impacts on important and permanent appointments. .

How can senior officers be better supported to manage their teams more effectively?

- Acknowledge the need for credible professional leadership and structure to enable efficient operational management of teams.
- Health requires a speciality and professional based approach to the management of teams to ensure clinical needs are met.
- Stable leadership;
- Clearly defined organisation values, strategy and KPIS to inform how the leaders manage;
- HR processes that remain stable and don't change and appropriate level of approvals. If a decision to recruit every staff member has to go all the sway to the CE the ability to be responsive at senior management level is hampered.

Employ people that have the experience, credentials and are accountable and hold them to account. Do not employ people because they are on your "A team" and are friends!

How can public sector agencies work together to better share and exchange workers' knowledge and expertise?

- This is discouraged under ABF as only direct patient contact is costed. Consequently, cross sector consultation, collaboration and case discussions and managed down and not permitted in the costing of clinician activity. This needs to be considered at a health and activity level.

In what ways can the public sector draw on the knowledge and expertise of the private sector?

How could the performance management and accountability framework be strengthened to give incentives for collaboration?

- There needs to be clear recognition for the need for appropriate professional and clinical support to enable underperformance to be recognised, supported and then managed.
- Clear operational definitions for clinical supervision, professional supervision and performance management
- Appointing appropriately skilled professional coordinators / managers enable streamlined communications and processes to ensure implementation of performance management and accountability.

How can the public sector increase diversity within the workforce?

- Have external HR members in on panels or have random audit and review of selection processes;
- Have clear processes within the public sector standards to support open dialogue and ability to question and discuss rather than look for management teams that just say yes and do what they are told. Current pathway of speaking to your line manager and going beyond your line manager as a performance issue is extremely problematic and at the core of the corruption in the management processes across health.
- Questioning or clarify or demonstrate healthy skeptism - this is discouraged or reprimanded.

- Site HR is not independent but groomed by higher site management.

What is required to support a sustainable workforce in regional WA? -support to metro services for use of telehelath and telemedicine recognising regional needs to link in for both specialist support and access to crucial services not available in regions. Training units funded by the government that support and fund training and education

Theme 3: Enabling the public sector to do its job better.

What process and system changes could help the public sector adapt to new economic and social conditions?

- Have an open investigation and review of the financial demands on the system created by multiple tiers of high level management.
- Stop cutting front line clinical positions to boost tiers of autocracy and poor performance.
- The fractional FTE cut from front line clinical positions have a significant impact on the clinical services delivered, whilst higher level management positions with no clinical portfolios are on a significant increase. A reduction at this higher level management positions will provide the necessary funds to provide a more sustainable workforce which has direct impact on service delivery
- All clinical management positions to have part time clinical time attached to positions

Have stated and measurable service delivery KPIS's

What new technologies could be used to achieve better service outcomes?

How can the public sector better collaborate – both between agencies, and with the private sector – to operate more efficiently?

How can the public sector be more accountable for service delivery? stated and measurable service delivery KPIS's for recruitment, retention of staff, performance management processes, HR issues etc.

- Hold higher level management to account and demonstrate credible, open, transparent processes to ensure appropriate governance

How could the public sector be better organised to operate more efficiently?

- Model reviews and approved changes to team structure and governance should be done by qualified (ideally external) consultants,
- Benchmarking with services that are high performing efficient financially viable,
- Have a governance structure that is free of bias or conflicts of interest.
- Clinical service planning should be done with professional heads and senior clinicians who work in the clinical area, not generic operational managers who have no clinical training, specialist skills and experience.
- Review processes require independent analysis and decisions made by current managers who are vested in an outcome is corrupt and problematic.

What skills and tools are needed to ensure better outcomes for the community?

- The community requires access to credible and safe clinical services.
- Stop diluting the professional workforce, to the point that the services delivered compromise clinical practice
- Appropriately skilled workforce which works within the scope of their practice
- Stop management directing, coercing and bullying staff to work outside of the clinical expertise or compromise their clinical practice standards.
- Look broader for cross collaboration to ensure appropriate funding sources are utilised and stop looking at such a vast debt issue with micromanagement approach of minimal FTE reduction

What obstacles exist and how can the public sector overcome them?

- The current health structure from the highest level down requires serious consideration and review. The levels of redundant management, who are directive and autocratic, who are removed from the front line clinical practice, who do not invest in patient care, but have business and finance review as the primary goal
- Review where the authority sits for the appointment of high level management. How does one justify the reduction of front line clinical FTE by 10-15 FTE, whilst simultaneously announcing a further 5 Co-Directors!

How can government contracting and purchasing practices be improved to get better results?

Understanding of how the contractors work, how they set their KPIS's , very careful contract management. and contractual agreements that can be reviewed in a timely enough way to be responsive to the service delivery requirements eg contract management is so complex with Serco and Health at FSH that getting a change to the contract to enable an issue to be addressed can take a year.to negotiate. Recognition that some things should not be contracted out to organisations that do not specialise in heath or do not have relevant health experienced staff in the team that understand the area they are providing services in. Perhaps have more of a shared/ collaborative approach - some Health/ Clinical staff responsible jointly for services contracted out eg to Serco staff rather than handing over the whole service to the contractor. Joint/ shared KPIs too

How can any positive changes made become embedded as standard practice?

Investing in clear processes and individuals who honour governance structure to promote high quality service delivery.

Our Ref.: HO.180.17

Mr Iain Rennie
Chair, Service Priority Review

[redacted]

18 September 2017

Dear Mr Rennie

Re: Service Priority Review (SPR) – Feedback on the Interim Report

Thank you for the opportunity to provide feedback on the Interim Report issued by the Review Panel at the end of August 2017.

The Union appreciated the opportunity to meet with you on 17th May 2017 and follow up with our submission dated 23rd June 2017. Our submission noted that the top three workplace issues for our members are security of employment, reasonable workloads, and salary and benefits. Our feedback on the Interim Report has focussed somewhat on these three issues.

When we met on the 17th May we discussed the fact that the Government had committed to undertaking the Sustainable Health Review (SHR) and that care needed to be taken to ensure that the work of the SPR and any recommendations in your final report due in October 2017 did not restrict the work of the SHR that is due to report in March 2018 (an extension is likely).

Our specific comments and feedback on the Interim Report follows.

1. In defining 'the public sector' (page 5), the Report has applied a very broad definition that goes well beyond that contained within the Public Sector Management Act 1994 (PSM Act). The Union believes that greater attention should be given in the final report and recommendations to differentiating between those that apply to the Public Service as defined by s34 of the PSM Act and those that have wider public sector application.

2. By way of example major governance reforms have been introduced in WA Health commencing with the Health Services Act 2016 (the Act) in July 2016. Implementation of these reforms is ongoing and it is important that they be allowed to take root. The last thing the health workforce needs now is further structural change. Of relevance to the SPR is that the functions of the Department of Health (being a part of the 'public service') and those of the board governed health service providers (separate employing authorities and part of the 'public sector') have been defined in the Act.

3. The Report includes higher levels of public sector wages compared to other states as contributing to WA's high debt levels. Greater weight in our view needs to be given to the other factors identified in the Report ie high per capita levels of infrastructure spending and declining general government revenue (including GST distribution). The then Barnett Government added significantly to the wages bill with well above government wage policy increases to nurses during the lead up to the 2013 state election. That level of wage increase was not shared with the wider public sector and public service.

4. The "Public Sector Interstate Salary Comparisons" (Figure 5) create a false impression of overpaid Nurses, Teachers and Police. They are a point in time comparison that does not take account of the bargaining cycles let alone the differing economic circumstances in each of the States. For example, the Nurses comparison with Victoria fails to recognize that the Victorian Nurses Enterprise Agreement has locked in annual increase averaging over 3% per annum through to 2022. If the WA Public Sector Wages Policy limiting increases to $1,000 per annum continues to be strictly applied then by the 2021 WA State Election Victorian Nurses will be paid more than WA Nurses.

5. The Report references the Productivity Commission, 2017 Report on Government Services (page 8) and various other WA Government reports (page 9) in highlighting WA's apparent inefficiencies in delivering key public services. In relation to health outcomes and performance these reports whilst valuable in themselves often become out of date by the time of publication. Much more needs to be done to develop real time data that is relevant and publicly accessible to measure performance. Health has made some progress with this in relation to national targets such as in emergency access targets, hospital activity levels, surgery waiting lists and waiting times for outpatient clinics.

6. The Union concurs with the Panels observation relating to previous reviews and that "...the public sector has been unable to move from problem identification to action and then to sustained and effective solution." In Health, the March 2004 Health Reform Committee report (the Reid report) is a case in point. The SHR is separately looking at this. In our view, much of the implementation around the health workforce (planning and development) fell away with a change in State Government in 2008. Hence the importance of building in some level of immunity from changing political landscapes.

7. The Union supports the general directions described in "Building a public sector focussed on community needs". As stated previously much of what the SPR has identified under this heading in the Interim Report will need to be examined in the Health context by the SHR. We agree that upfront investment in skills and infrastructure is required to support digital infrastructure but caution against a "robbing Peter to pay Paul" funding approach. In Health, new or additional funding will be essential.

8. Note 18 to the "Reshaping and strengthening the public sector workforce" section states *"Some aspects of this section of the report apply only to the public service as defined under the Public Sector Management Act as it relates to workforce management and accountability."* In our view, this blanket note is not sufficient and the final report and recommendations around workforce needs to specify what sections apply and what do not.

9. According to the State Budget Papers 34,336 FTE positions employed directly by Health Service Providers are funded for 2017-18. These are NOT public service positions. Parts 3 and 5 of the PSM Act do not apply. The new Health Services Act 2016 prescribes the employment arrangements for health service employees.

10. The Health Service Providers' workforce has a long history of industrial coverage and conditions of employment distinct from the public service and other government agencies. The workforce covered by the WA Health - HSUWA - PACTS Industrial Agreement 2016 enjoy salaries and conditions of employment that differ significantly from those applying in the Public Service. The current Agreement and its predecessors have terms and conditions that since 1955 have evolved to meet the needs of Health Service Providers and their employees. HSUWA members expect this to continue.

11. However, there are a number of issues identified in the Report that do apply to Health

    - Use of fixed term contracts. Despite employer commitments in our industrial agreement to preference for permanent employment, high levels of fixed term contracts remain.
    - Classification system that is outdated and not responsive to the changing health workforce.
    - The inflexibility of State Government wages policy. It prevents meaningful bargaining around wages and conditions and acts as a barrier to identifying and implementing efficiency measures.
    - Central agency involvement in industrial relations processes including enterprise agreement negotiations is overly bureaucratic and not productive to achieving outcomes.
    - Lack of effective workforce planning. As previously stated it is our view that the pathways to workforce planning reform initiated from the Reid Report fell away with a change in Government in 2008.

12. The Report recommends adoption of a whole of government targets approach. Whilst the union can see the value of this for transactional and regulatory type services it is problematic for services to large cohorts such as health and education. Health already has various service delivery targets some of which are national in nature. Funding mechanisms are complex and activity based. Given that this undoubtedly will be examined by the SHR we believe that health should be excluded from any whole of government targets at least until the conclusion of the SHR.

Whilst we have not provided feedback on all aspects of the Interim Report we trust what we have will be taken into consideration by the SPR Panel in your final Report and recommendations.

Should you wish to discuss further please do not hesitate to contact me.

Yours Faithfully

Dan Hill
Secretary

hsuwa
with you at work

Our Ref.: HO.184.17

Mr Iain Rennie

Chair, Service Priority Review

[redacted]

18 September 2017

Dear Mr Rennie

Re: Service Priority Review (SPR) – Feedback on the Interim Report – Interpreters and Translators.

Thank you for the opportunity to provide feedback on the Interim Report issued by the Review Panel at the end of August 2017.

In addition to the general submission addressing specific provisions of the interim report we wish to raise the issue of Interpreters and Translators providing service to the WA State Public Sector. We are particularly focused on Interpreters as Translators generally work online. Interpreters deal with the spoken word, Translators with the written word.

In Summary

The purpose of this submission is to propose that the provision of Interpreter Services in the WA Public Sector should be significantly reformed by creating a standalone Interpreter service modelled on the Victorian Interpreting & Translating Service (VITS.), either as a standalone centralised service or as a part of the already established, wholly government owned, agency for casual and temporary Nurses, NurseWest. NurseWest is a standalone service operated under the auspices of Health Support Services. (For more information on NurseWest go to http://ww2.health.wa.gov.au/Careers/Occupations/Nursing-and-midwifery/NurseWest . For details of VITS, see links below.)

We expect this is not a matter that would have come to your attention to date as the matter of the engagement, employment, professional development, and quality assurance of Interpreters is dealt with on an ad hoc basis, notwithstanding that access to vital services and fundamental human rights for people with poor or non-existent English skills, is highly dependent on the work of Interpreters and translators.

Some Numbers

WA is home to people from more than 190 countries, speaking approximately 270 languages and dialects (including around 50 Aboriginal and Torres Strait Islander languages). According to dated information on the web site of the Office of Multicultural Interests, 31% of Western Australian were born overseas, 18.5% speak a language other than English at home. There are approximately 70,000 Aboriginal and Torres Strait Islander people. According to the Western Australian Language Services Policy 2014 and guidelines (Introduction by the Minister) 1.6 % of the general population and 13% of the Aboriginal population do not speak English well or at all. (see

https://www.omi.wa.gov.au/Resources/Publications/Documents/languages/Language_Services_Policy_2014.pdf)

Implications

Failure to engage interpreters and translators can have serious legal implications for State Government agencies.

Failure to properly engage support and pay Interpreters has significant implications for Interpreters and the quality and sustainability of Interpreter and translator services.

We will be raising this issue with Sustainable Health Review (SHR) also. However, while Interpreters provide a vital service in Health Services, they are an important service across the State Government.

Shared Services Do Work

We note in the interim report at page 42 under the heading, Preliminary Conclusion, it is noted:

> "... decommissioning of the Office of Shared Services following a failure to meet its aims, seems to the Panel to lead the public sector to regard opportunities for common systems and processes with undue suspicion. This constrains choices in so many domains; opportunities are missed for building better systems, solutions to complex problems remain elusive and economies of scale are passed by."

NurseWest had proven successful in meeting its aims. HSS has worked reasonably well for Health and is currently on an improvement drive. PathWest also works very well as a State Wide public sector centrally managed Pathology service. We believe the State would be well served if it were to create a single service point for Interpreter and Translator services and the employment of Interpreters and Translators.

The issues in summary

The primary users of Interpreter services in WA are WA Health and Justice (in particular the Courts). Police and Education are also significant users of the services of Interpreters and Translators. The Health Services Union of WA (HSUWA) is primarily familiar with Health but also have anecdotal knowledge, through our Interpreter Members, of other work that they do.

In Health there are a small number of directly employed interpreters mainly at Royal Perth Hospital and Princess Margaret Hospital (Child and Adolescent Health Services). These are almost entirely employed as casuals. There are a very small number employed on a full time basis, mostly as coordinators of the Language (Interpreting) Services.

Most interpreting services are provided via Private Agencies. The Agencies purport to engage the Interpreters as contractors on contracts for services. While they have never been tested, we believe that if these arrangements were to be tested, they would almost certainly be found to be sham contracts. Such contracts are in fact employment. Sham contracting is proscribed by sections 357 to 359 of the Fair Work Act. This is not only unethical and unlawful, it also creates a political and industrial risk for the Government.

While the numbers of interpreters involved in WA is unclear as there is no central registry, we believe there are between 500 and 800, possibly more. A few years back, NAATI said that there were 750 Interpreters on their books in WA, not necessarily all were practicing. In practice most interpreting services provided to the State Government are provided by a core group of around 350 qualified Interpreters between them covering most language groups.

In hospitals the Social Work Departments are generally responsible for the engagement of Interpreters. In larger hospitals they are engaged via Language Services Co-ordinators. In smaller

establishments, the arrangements appear to be many and varied but often arrangements for interpreters are made by clerical officers.

The ad hoc arrangements for interpreters creates a situation where:

- The vast majority have insecure employment, even in the most common language groups.
- They are often subject to arbitrary and capricious behaviour in regard to their employment including being in effect black listed if a user complains without any opportunity for redress.
- They are excessively dependent on the good will of those who engage them.
- There is a lack of quality assurance and, we are advised, at time s unqualified Interpreters provide interpreting services in complex situations.
- Government agencies are reliant on the private agencies to ensure that interpreters are qualified in the languages they are interpreting in and have met the required integrity checks. To the best of our knowledge the agencies do not have any formal processes in place to audit whether the Interpreters supplied meet the required standards.
- There is a lack of professional development and training.
- The lack of formal professional development training and regulation can lead to significant risk in regard to the provision of Health services particularly when it comes to matters, such as, ensuring clinical staff have a correct understanding of symptoms, patients have a correct understanding of diagnosis, that consent is fully and freely obtained in regard to medical procedures and that patients and clients have a full understanding of treatment including their role in treatment, self-administration of medications, exercise activity and the like.. There can be issues in regard to confidentiality and cultural awareness related matters, including matters that lead to nondisclosure of vital information.
- Similarly in Justice, particularly in the Courts, poorly trained interpreters who have not received relevant professional development can lead to a serious miscarriage of justice. We understand through members that the Chief Justice has a number of concerns in this regard.
- Interpreters can find themselves being directed to undertake compulsory training required by public sector employers in their own time, when other employees are paid to complete such training.
- They are forced to work on contracts for service with all that entails where clearly the engagement is employment.
- The opportunity for permanent employment is extremely limited.
- Places the Government in a position of supporting contracting out and sham contracting contrary to Government policy and the law.

We are firmly of the view that an employment model based on a single point of engagement augmented by limited resort to Private Agency supplied staff (ideally, Agency staff should be employees not subcontractors), would overcome most of the above shortcomings. In particular it would:

- Provide a centrally managed one stop shop for Interpreters and Translators including liaison with Private Agencies and specialised services, such as Auslan Interpreter and the Kimberley Aboriginal Interpreter service.
- Eliminate duplication of administration.
- Improve service efficiency and delivery efficiency including potential cost savings.
- Provide a platform for the delivery of proper quality assurance and for the delivery of professional development.
- Improve the confidence of users in the service and the quality of the service for all concerned including Government services and the members of the public who rely on Interpreters and Translators for access and service delivery to them and full access to their rights and opportunities and equality as citizens and before the law.

- Deliver much improved risk management.
- Provide a significant increase in both permanent employment and regular casual employment.
- Provide all of the usual safeguards, fair processes and procedures that are available to employees.
- Deliver a much improved interpreting service across state Government Agencies. Improved both in regard to the outcomes targeted by Government and the quality of the work for Interpreters and Translators.

We have previously tried an employment model in Health without the benefits of a single wholly owned centralised Government service but it was never widely adopted and in any case lacked the benefits delivered by a centralised service. The model also faced disincentives, not the least of which being the ease of getting a Private Agency to find an Interpreter as opposed to having to find one directly. There was also wage competition and undercutting and design problems with the employment model that was not specifically designed for Interpreters.

While our Union's preference would be for a centralised model based on NurseWest (it falls within our coverage), we note that, following an extensive review in Victoria, the Victorian Government elected to create an Interpreting Service that is a standalone unit under the auspices of a Public Service Department.

The Victorian Solution

The Victorian solution was to create a wholly government owned interpreting service, the Victorian Interpreting & Translating Service (VITS.)

Language Services - human services Vic.

The department has consolidated interpreting and translation services for human service related program areas. The language services provider is the Victorian Interpreting & Translating Service (VITS).

Services provided by VITS include:

- telephone interpreting
- on-site interpreting (spoken languages and Auslan)
- translations
- video remote interpreting.

To access VITS services, departmental user and funded organisations have been allocated an identification number (PIN) by VITS. The PINs will assist the department to monitor language service usage.

Relevant Links:

Interpreting Services – Victorian Department of Health and Human Services

http://www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/projects-and-initiatives/cross-departmental-projects-and-initiatives/language-services

https://dhhs.vic.gov.au/publications/language-services-policy-and-guidelines

VITS – Victorian Interpreting and Translating Service (Wholly owned Vic Government Service)

http://www.vic.gov.au/contactsandservices/directory/?ea0_lfz149_120.&organizationalUnit&d949a4ca-9c03-4bbc-a135-979134d551d0

Should you require further information, please do not hesitate to contact Chris Panizza at the HSUWA.

Yours Sincerely

Christopher Panizza
Assistant Secretary

74% Say staff levels too low

59% Say poor planning for wait lists

40% Say wait lists are up in their area

75% say not enough funding

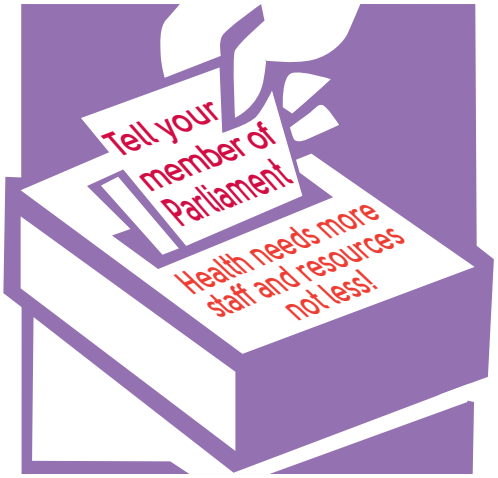
78% say have increased workload

hsuwa with you at work surveyed members and this is what you told us

59% say recent changes have compromised patient care

Top 3 workplace issues

1. **72%** secure employment
2. **65%** reasonable workload
3. **46%** salary



Are there any changes that the new State Government could make in your work area that would improve the quality of patient care without compromising jobs

	Responses
BUREAUCRACY	Reduce admin time to approve filling positions - goes through too many layers of authority, inefficient. Devolve authority to Heads of Department.
	Amalgamate Mental Health Commission with Department of Health so that health takes responsibility for mental health and there is reduced duplication of administration
	Devolve budgets to department heads. This would streamline many processes especially contract extensions which are still handled by many, many senior and highly paid staff. The devolution of budgets has occurred in other government departments (education) and is consistent with best financial practice.
	Tear up the contracts with the facilities management-an enormous waste of money. Include workers on the hospitals boards. Have a bottom up efficiency review.
	Audit the number of managers, make Heads of Service more accountable. Have more allied health representation at upper management level as particularly in mental health our specialist skills/role is being eroded and we are being forced to become generic mental health case managers by nursing and medical staff.
	Minimising paperwork instead of increasing it. Nurses and admin are spending a lot of time keeping up with new forms as forms are changing rapidly.
	Instead of cutting clinicians and creating boards.. how about a review of the over-bureaucratization of health.. it's not transparent and there is a culture lacking transparency. We have lost our patient focus and it's all about reducing the debt.. Get more frontline staff providing input instead of talk-fest for bureaucrats..
FUNDING	Less executives making decisions that don't help the staff or patients. Create more positions for all areas ie: clerical and nursing while offering more variable hours to help accomodate staff with families
	Permanent employment creates a more cooperative and smooth-running dept and reduces admin workload of renewing contracts which can take up to one month. Remove public service executive level and make all Health posts with involvement with the various institutions.
	Rid the WA Health Dept of as much ABF drivers as possible, as ABF has just led to poorer patient outcomes.
	Looking less at waitlist and throughput numbers and more at outcomes for clients.
	Yes look into amount of funding given to clients eg some have excess funds available whilst others with very high needs have little left and are paying high additional fees for service
	Ensure the full payment of the allocation of activity based funding and any supplements e.g. because of remoteness or patient population. Our supplementary funding has been deleted from the budget 2 months before the end of the financial year so that the region will now have a much larger deficit than that projected 3 months ago.
	remove activity based funding . The focus is on funding and NOT individual patient care and recovery in their own time and according to their own social circumstances
	Yes more funding for the agecare...
	Activity based funding compromises patient care.
	The way activity based funding has been adopted needs to be reviewed. It's terrible at the moment and is resulting in increased costs and worse patent treatment
	I believe the health budget will have to keep increasing with the ageing population. I also believe we all need to become more efficient and in my area that means we need more beds because we are forever on hold due to lack of PICU beds which means lack of beds on the wards.
	Ensure budget consistency without unplanned budget cuts
	Improve funding to health department to ensure adequate staffing and services available. Especially with the increased demand on the public health service
	give funding for adequate database and Co-ordination of programme...we are the poor cousin of the other states
	Fund our department as we have to fund ourselves and are only just starting to be recognised for the work we do and its benefit to patients
	continuous budget cut will only do more damage
	Funding appropriate improvement for PSOLIS system to catch up with the SSCD documents to prevent doubling of administrative work for Clinicians whose time will be better utilised providing client care!
IMPROVED PROCESSES	less paperwork - more time for direct patient care
	Not focusing on activity based funding but being more client centred
	Current level of ABF is insufficient to manage waitlist. Don't cut jobs but realise savings elsewhere - for example the public-private partnership for FM services is expensive and inefficient - make it in-house and save money while making the hospital more efficient. Improve administrative processes to make decisions and actions easier and therefore more timely - this will save money. Make hospital systems and processes more efficient, including ICT systems - this will also save money but does require initial expenditure as an investment in future efficiency. Redirect any savings to addressing the waitlist by providing more resources to meet actual demand.
	ABF is simply compromising patient care from a mental health perspective, repeated complications and readmissions demoralise patients, distress families and make providing related psychological care difficult.

IMPROVED PROCESSES Cont.	more funding for transport for patients coming for outpatient appointment. especially people who do not live in the FSH catchment area.
	Increase resources for community mental health. In particular, adequately qualified and skilled staff in community mental health clinics to assertively manage high risk consumers with complex issues. Sto the fragmentation of care where NGOs are contacted to do work for which they don't have adequately trained staff and where they are unable to manage the risks of looking after clients with complex and chronic mental health conditions.
	An effective health system requires recognition and investment in the non hospital bits of the system. we need to invest in keeping people out of hospital, child/family health and better coordinating care.
	1.Funding for resources, therapy equipment and materials. 2. Funding to attend work related training/PD. 3. Funding for building or leasing of suitable buildings for Child Development Services.
	Increase in mental health and accommodation options for those suffering with mental health issues, homelessness and drug and alcohol rehab to be increased. Increase services and access to support parents . friends of those affected by drugs and alcohol.
	yes, conduct an efficient audit for patients on waitlist to establish if they still need to be seen (audit was performed 1.5 years ago, very inefficient, no communication between staff doing the audit and staff in clinics, very frustrating for us staff and patients) Develop appropriate referral templates for GPs and education of GPs to improve referral pattern to Neurosurgery Department increase number of staff (advanced scope physiotherapist) in order to triage patients in Neurosurgery Spinal Clinic
	Invest in behind the scene corporate based systems and data gathering to better enable working smarter, better and safer.
	Increase access to psychological services
	Ability to backfill, improved technologies for oh&s and more training. Cooperative planning between departments.
	More access to outpatients facilities, removal of our state wide service from under a single hospital umbrella
	Investment in electronic infrastructure that supports clinical care whilst meeting the need for data collection and records management
	Recognition that sole practitioner positions in large country hospitals is unhealthy and unhelpful for patients. Impossible to do a VERY GOOD job. Just OK outcomes mostly...might account for why there is such a significant percentage of pts. who return on regular basis. Follow-up and outreach post-discharge is imperative. This model should see an increase of staff.
	focus on preventative health strategies
	Reduce silos and manage referrals
	Elearning is not time effective. Getting 5 emails a week telling me I am overdue in completing elearning wastes my time and does not enable me to keep up with training needs. Elearning that covers all age areas of mental health when all staff are working in one age group (child, adult or older adult) is time wasting and infuriating. Get rid of elearning
	Communication training for management within CAHS and CAMHS!! Review (and reduce) level of admin required by direct care staff
	Improving efficiency by increased utilisation of IT solutions (increased access to computers - e.g. bedside; reduced need for plethora of paper-based forms).
	Outpatients clinics need to have some admin time factored in as there is an increasing demand on documentation. Electronic record keeping would save duplications of notes and speed up discharge letter writing... prevent a backlog of paperwork...less stress about this
	We are a community based service (attached to North Metro HS) so the only improvements are likely to be interfacing with the Health services
	Allow some professional discretion re provision of services rather than having to meet set limit eg 6 therapy sessions etc.
	Remove privatisation of public hospitals
	Address the problems associated with drug use as drug affected patients are drawing resources away from patients in need of health services
	To treat healthcare as a service and not a BUSINESS!
	Stop privatisation
	Stop the outsourcing of typing to the Eastern states. We have fully trained secretaries in RPH who are more than willing/able to do the typing
	Fremantle Hospital - open operating theatres on Saturday and Sunday and try to bring down the elective list blowouts. This will also improve staffing welfare at the hospital.
	They could encourage specialist services to reside in Busselton to help with the after hours service so Bunbury Hos doesnt get the overload of emergencys that Busselton Hospital could easily do
	Allow us to have an after hours drug imprest room so that prescription drugs no longer float around the hospital willy nilly regardless of if they are on imprest or not. There is no respect for prescription drugs or their cost. It would save so much of the stuff we throw away every single day and stop nurses tubing drugs around the hospital like candy.
	By not closing down essential Mental Health Services, when there are so many requiring help
	More Aboriginal Mental health workers are needed at the CAMHS clinics one clinic doesn't have any.

IMPROVED PROCESSES Cont.	Put pressure on the bureaucracy and management team of FSH Allied Health to listen to senior clinicians.
	Provide an outline of the impact of changes to the Public Health Act and local government is there an impact on WACHS staff
	open the 4 closed beds on older adult mental health
	Reopening Fremantle Hospital; increasing beds at Bentley and Royal Perth Hospital, anything to improve capacity to cope with growing population needs.
	changing the new Allied Health service model back to the old sydtem /direct discipline specific mangement model. Removal of mandatory uniforms for Allied health. Establishment of government funded community based specialist services such as chronic disease care model.
	Better funding in mental health. Post discharge support is required.
	Greater resourcing for Oncology Services at RPH to better manage clinical and service demands
	increase funding for clinical support onsite for Telehealth and Palliative Care across Kimberley and Pilbrara
	I would be pleasantly suprised if the government would change things at Armadale hospital. However at the very least I would like an investigation of the current executive teams actions over the last 24 months and all of the current events going at Armadale Hospital. I believe something similar has recently happened at Princess Margaret Hospital after staff had finally been pushed too far. Maybe the new health minister could intervene before this situation gets out of hand and get some positive media.
	Review the ceo an coo micro management of work practices and employment process that take 6 weeks minimum to get people employed. If fte is x and we can employee in the fte guidelines then it should not need to be signed off by coo. It takes at least 6to 8 different people to get 1 person to be approved. Cut red tape. Let people do their job with checks and balances. Human resources department who completes job interviews, paper work induction to health instead of staff who are not trained doing the job. Lack of training in staff when requested to step up. Restructuring of departments taking 6 plus years and still on the merry go round. Understand the work from people on the ground not people in ivory towers that have never done the job or even been to remote areas. Perth makes decision and have no idea if it will work in remote areas no wonder the budget is in the red. The money that is wasted on re work. Finance Department in Bunbury not paying account on time as it is all done from Bunbury who splits accounts out and then loses them. Water accounts not being paid in correct time frames of when due. The waste is unbelievable . The fish rots from the head down and unfortunately the arrogance and out of touch business management practices. The management is in major business has moved past this type of management it back in the 60s
	State wide strategis vision and model of care for the delivery of mental health services. Much stronger focus and strategic framework for increasing and improving community based mental health teams, less emphasis on inpatient care. Much more discussion and planning of youth services in the community. A plan, framework and model of care for tackling ice use and addiction.
RESOURCES	Forward planning, ensuring there are adequate buildings to deliver services from. Minimising change. Reducing unnecessary administration-this is a huge cost in CAMHS the child part of the system is constantly putting in systems applicable to adults and not young children
	I work in a community mental health clinic. Increased documentation requirements over the past few years results in face to face time with patients decreasing. Work to consolidate documents and make all documents available electronically, across sites (eg through PSOLIS if possible) would improve this. I also find some employers reluctant to grant study leave, and unwilling to consider helping to cover cost of cpd courses. Not supporting staff to complete cpd can of course adversely effect patient care, if staff are not 1. Staying up with current techniques/research and 2. Not having some reflection time/space and returning to work inspired!
	Respect us. Also if CDS is only seeing young children then say that and stop saying we see all children. See children until they have sufficient improvement, not discharging as they have had 4/6 sessions.
	OPH needs to be taken out from under SCGH management as the interference and transfer of resources impedes OPH being a top grade service.
	Development of Pathways for alcohol and drug services. Development of Pathways for Mental Health Services. Reform and Develop Mental Health Service delivery... act on the Mental Health reform
	Stop ward closures
	to achieve goals set by health department, inadequate beds and staffing levels
	Last winter the black bed status and ambulance ramping was concerning. The population is ageing and it is becoming very apparent in the acute care setting. Beds! beds! beds!
	Having facilities that aren't out of date. Maintain support for specialist services.
	Funding appropriate FTE; primary prevention funding
	Higher staff levels to address population growth. Funding for long term treatment
	More funding for staffing and stop putting their heads in the sand thinking they don't have a problem. Nurses are in crisis and the government keeps giving everyone "lip service" saying they are coping!
	More funding to employ more doctors, theatre availability and open more beds to help reduce waitlists.
	Provide adequate resources for effective patient care. Outsourcing health services is a very inefficient way of providing services.
	increase staff, revised and streamline internal processes and documentation within CAMHS
	increase permanency employment positions increase outpatient clinical psychology therapy capacity in hospital settings, to reduce readmissions and admission lengths.

STAFF	Better planning and use of staff across all areas, look at areas where duplication of work particularly in administration areas
	Properly resourced to enable innovation - take some examples from NSW Health Clinical Excellence Commission.
	Yes, reinstate best practice model of care and management for patients undergoing elective joint replacement surgery to ensure their surgical outcome is optimised. Improve the environment for staff working on the ward. Improve the staff clinical knowledge so that patient care is not compromised. Reduce bullying in the workplace and toxic environment. This really affects patient care a lot.
	access internal DoH experts on clinical change and reform programs
	Reduce the red-tape in filing cost-neutral positions. Meet national guidelines for staffing per population. Mandatory training in management skills for staff in management positions.
	Spending money on much needed repairs to our building and providing the IT systems to support patient care
	Get better managers
	Ask nurses to live in the real world and get back to " hands on " nursing instead of paperwork!!
	Stop the bullying behaviours listen to frontline staff adopt a unified approach Govnext is not the answer and won't save money
	Give australians the permanent jobs not contracts.
	Admin staff cuts at PMH/PCH impacting on current staff and their workload.
	Increase FTE for direct clinical staff, have KPI's for direct patient contact.
	stop cutting occ health and safety... you need to look after the workers or the whole system will fall apart!!@!!
	Increase nursing staff and administrative staff so that there is less stress on the staff that are currently trying to do their jobs.
	add more remote rural mental health professionals
	Value the input of Social Workers as an integral part of the Ward team. Increased marginalisation of Social Workers within the Armadale health service has resulted in overworked, social workers who are relegated to a demountable a long way from the ward, improved consultation and provision of basic tools of trade such as a reliable workspace with a computer available when needed, provision of PENS (yes we are now being asked to provide our own and with lengthy hand written clinical notes this is significant and reflects the petty policies lack of respect for staff). Adequate staffing levels and access to permanent FTE and stability of employment.
	review staffing ratio. current staffing agreed to when we were south metro. Have had additional outpatient area coverage and taken on Midland in and out patients under east metro without negotiating new staffing levels to service this. Now difficulut to have staff take leave and continue service to patients. I recive multiple telephone calls from staff and patients wanting treatment service and I'm not able provide this with a limited sessional time in EMG/NCS area. I get depressed as there is no solution on the horizon.
	More staff
	Longer staff contracts and long term contract staff being appointed permanently
	outdated equipment. Too many staff on fixed contracts.
	Ensure no more staff cuts so we can actually give our patients what they need instead of feeling like you are running through your day stretched to capacity
	Training
	More jobs
	Fill vacant positions and give people security of employment
	Increase staffing levels to cope with demand
	Provide more staff so we can do our jobs adequately rather cutting staff! Improve computer systems and facilities so services can be more efficient .
	improved staffing numbers, adequate equipment, change of roster design, a more stable working environment, conditions in old hospital aplourable.
	staffing and employment stability
	I would love to say increases in staff rather than fussing about infrastructure, which has been the benchmark of the last government. It is nice to have new facilities, but not at the expense of staff
	Increase existing staff hours or put on extra staff to cater for the increased workload and training provided for staff
	Support patient centred care & allocate staffing resources based on clinical demand
	Allow the filling of vacant positions
	Not unless they are happy to upgrade the hospital and provide more money in the budget for extra staff across the board

STAFF Cont.	Stop putting unrealistic pressure on doctors, nurses and all staff in hospitals. Stop employing boards and executive to make decisions regarding the workplace when they are so out of touch with the real world
	Firstly happy staff members equals a productive workplace.
	Invest in human capital by providing hard working employees job security and invest in their skill development to improve service delivery and efficiency, minimise staff retention
	Staffing no.s increased, medical SSS project waste of money, and not improved services.
	More clinical staff less executive staff
	Cut red tape and employee more staff
	Stop outsourcing of medical typists. Bring back more admin staff
	Restore fte to previous levels to allow all machines to run at capacity
	Increased staffing
	No privatisation of services promised. Make contract workers permanent. Increased low level supervisory staff. Support for new graduates.
	Employ more skilled staff (e.g., psychologists)
	More staffing
	Hire more staff to meet demand.
	Appropriate staffing of public hospitals
	If we could have 4 full time officers back that we lost it would be a good start
	Employing more staff
	The creation of permanent positions rather than contracts.
	Improved recruitment & HR process, especially timeliness
	Increasing staff levels
	Employ enough people to actually allow staff to take leave so that everyone doesn't become a leave liability (this would also improve moral and therefore efficiency) Employ enough people so that the workloads are actually national standard and not at least 30% above (this is not safe and is causing more sick days of staff which worsens the problem). Pay staff for on all work or at least recognise the extra work on call do.
	More staff!!!
	Increasing staff levels and competencies of staff
	More permanent positions
	Provide job security and development of all (not just clinical staff) staff in the health sector.
	Nurse to patient ratio
	Correct staffing for the required expanding workload
	Sort out the current staffing issues quicker so we can all get on with doing our jobs better
	More staff.
	Raising staffing levels
	Increase staff numbers
	More staff would increase operation hours, thus decreasing wait times and workload
	Being realistic in our care requirements. 1 person cant do a 2 person job forever. Staff that are less stressed are more productive.
	More fte! More permanent jobs! Less changing and restructuring
	Increase permanent jobs. Increase fte,
	Allow for substantially vacant positions to be filled (not short term contracts for years on end).
	Employ staff to ensure that patients are well taken care of
	Ensure enough junior doctors are employed

STAFF Cont.	Equity with workload amoung the tertiary hospitals in the 5 health services
	Allow us to hire more staff - we need additional FTE to reduce waitlists, as well as to cover annual leave and sick leave. At the moment, if one person is sick, or on AL we fall apart. We have high sick leave and stress in the department as we all work so much harder as not to cancel patients.
	Employ more staff to meet staffing levels and meet workloads
	Reinstating manpower that has been culled to fit the preferred profile of health. As an engineer there hasn't been any reduction in facilities but the manpower has been cut.
	Decrease workloads. Increase staffing. Inpatient settings have capped staff-patient ratios based on bed availability (except ED) but community mental clinicians expected to accept new referrals despite very high caseloads and inability to provide timely care.
	Make sure empty FTE roles are actually filled.
	More staff
	funding new recruitment where there is genuine need for more staff
	Beyond increasing FTE, no.
	Additional staff
	proper staff resourcing
	Increase staffing and permanent positions. advertising to public that acute hospitals cannot solve social problems and is not an appropriate place to present. more education on arrival to hospital on role of the acute hospital to family/carers to help manage expectations
	More money for more staff
	Listen to staff who know how to care for patients; resource staff at the 'coalface', rather than spending so much time/resources on restructuring for effiencies and management simply continues to grow, without any benefit to patients.
	Provide more budgetised training to staff
	With increased patient volumes. We need more staff
	Increasing the jobs and staffing levels in such a small department. Continuous support for training and professional development. I am a strong believer that if the workplace is going to benefit from the person's increased knowledge/experience, then the workplace should fund this.
	Move staff from FTC and casual positions to permanent so their is consistency of staffing, knowledge build and less gaps in staffing
	Commitment to training, follow up, review & quality improvement of work. Measuring & improving work quality
	increasing the number of nurses
	Assess Staff levels.
	more training
	Increase maintenance staffing levels
	stop casualizing the workforce and give fixed term contracts - job security and less time messing about with HR - more time for clients
	Spend more money on staff and patient care than on paint and carpets.
	need more staff to see more new patients to reduce waitlist times
	Employ more experienced and good quality health care workers.
	increase staffing
	Stop the "1 year contracts" which is most of our new placements. Stop the hiring freeze. Realize that continuously compromising quality to meet deadlines will eventually just cost more and compromise patient safety.
	Increase in clerical staff. Our dept has had an increase in medical and nursing staff however a decrease in clerical staff - very busy dept.
	The only way to improve pt. care is by increasing staff numbers. Nurses are too busy to give pts. the care they deserve. It's not safe!
	Increase FTE, encourage training and professional development
	increasing the bed capacity . hospital was built to small for the population.
	Number of senior staff reduced from 5 to 2 should be increased to 3
	increase number of staff who are dealing with patients on a daily basis. you cant provide a good service if you are trying to do the job of 2 people
	Employ more clinical FTE and review executive positions so as to provide improved service delivery

STAFF Cont.	Back fill of staff on leave. I work in a community team where pts may not get seen because we dont have enough vehicales to outreach
	Provide a increase in FTE for training.in the areas OHS,and infection control skills
	More staff - and on permanent or long-term contracts
	Consolidate permanent workforce. Discontinue the use of vast numbers of Locum Staff recruited from around the world. Provision of airfares, accommodation and hire cars for locum providers travelling back and forth weekly is an outrageous expense. Audit the use of Locum Services in Bunbury Hospital.
	Have realistic staffing levels
	to make sure patient /nurse ratios are safe
	Increasing staff levels so current staff are not working under extreme pressure.
	Ensure people don't work excessive overtime, less meetings and reports (don't achieve much).
	Agree to increase FTE in administrative services to cope with existing and future increases to workloads
	not sure - possibly if they offered permanent positions to clerks - this would make a huge difference in job security
	review staffing level
	more staff per client ratio at the moment we are so busy we cannot provide the quality of care that is required and are unable to spend any social time for clients which is sorley needed
	Ensure job security. NO FORCED SEVERENCES!
	More staff.
	Offer longer term employment and give incentives to retain staff/migration tied to rural placements of a decent length of time 5 years.
	less stress, better work space/stations, actual chairs that give support etc, having a place to put your stuff. recognising impact of stress on workers
	More staff, more work space for clinics
	More staff needed.
	Increase staffing levels - clerical job freeze has had major impact on workloads - i.e. boxes of outstanding patient result filing etc in Cancer Centre is a potential danger
	Provide job security and enough staff.
	stop cutting our admin staff.
	better education for clinical staff
	More staffing in Mental Health wards Ratio often same as acute wards, levels of violence etc not considered
	People will not apply for positions that don't have a permanent contract. We are finding it difficult to attract and retain staff with specialist Mental Health training.
	Attract the best staff by having full time permanent employment
	Increase staffing
	Stop the use if consultants and privitisation
	Employ more staff and cease privatising transcription services
	Security that staff freezes will not occur.
	Job security,permanency quicker,more flexibility