Health
Northern Sydney
Local Health District

# Review of MVH Allied Health Service

## Report Feb2024

**Review**

**Contents**



# EXECUTIVE SUMMARY

## Introduction

In July 2023, the Health Service Union (HSU) raised concerns with Mona Vale Hospital (MVH) about Allied Health (AH) workload under the Work Health Safety Act (Appendix 1). The issues raised included AH staffing not meeting rehabilitation standards, unpaid overtime, small team sizes causing fatigue, no coordination of inpatient beds with AH capacity, and disruptions due to changes in outpatient workload during the NBH transition.

Immediate measures were taken to ensure a safe work environment, and a Risk Management Plan (see Appendix 2) was implemented. While developing the plan, it became clear that a more thorough review was necessary to address the HSU's concerns.

Following discussions with MVH Executive, AH Heads of Department, and HSU, it was agreed that Jane Woolgar, MVH Allied Health Manager, would conduct an Internal Review of AH Services. This review, part of the overall WH&S Risk Management Plan, aims to comprehensively examine the concerns raised during the dispute.

## Objectives

To investigate concerns raised by MVH AH staff, including:

- Current staffing insufficient to meet workload
- AH staffing does not meet the Australian Faculty of Rehabilitation Medicine (AFRM) staffing standards and is staffed at a lesser amount to the other NSLHD rehabilitation sites
- Outpatient FTE not in alignment with caseload and complexity.
- Increasing complexity of inpatients requiring greater time investment into each patient
- Increasing complexity of outpatients requiring longer appointment times and more frequent reviews leading to increasing waiting lists; mismatch of complexity of patients to FTE and skill set
- Flat structures of departments and lack of senior clinical support to level 1/2 clinicians resulting in difficulties with staff retention and recruitment.

## Summary of MVH Allied Health Services

MVH Allied Health includes 60 FTE and a headcount of 82 staff over 3 sites – Mona Vale Hospital and Community Health Centre; Brookvale Community Health Centre (BCHC) and the Manly Adolescent and Young Adult Hospice (AYAH), covering the following services:

- Nutrition and Dietetics (N&D)
- Occupational Therapy (OT)
- Physiotherapy (PT)
- Podiatry
- Psychology
- Social Work (SW)
- Speech Pathology (SP)

**MVH Allied Health Organisational Chart January 2024**

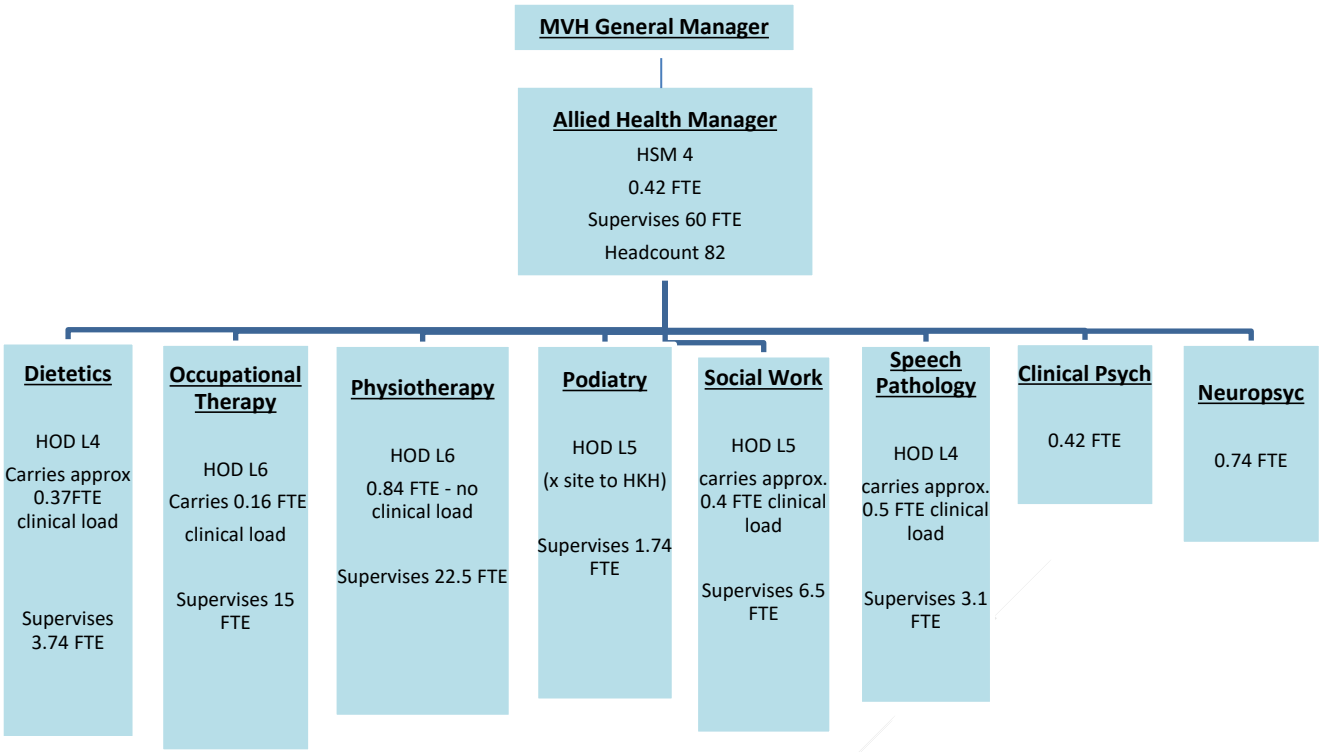



**Table 1: Summary of Departmental FTE and Classification**

| Allied Health Manager – HSM 4 - 0.42 FTE | | | | | | | |
|---|---|---|---|---|---|---|---|
| | **N&D** | **Occ Therapy** | **Physio** | **Podiatry** | **Social Work** | **Speech Pathology** | **Psychology** |
| **HOD** | 1 | 1 | 0.84 | 0.5 | 1 | 1 | N/A |
| **L4** | 0 | 1 | 1 | 0 | 0 | 0 | |
| **L4 Positional** | 0 | 0 | 1.47 | 0 | 0 | 0 | |
| **L3 senior** | 0 | 2 | 1.63 | 0.21 | 0 | 0 | |
| **L3 positional** | 0.32 | 0.42 | 3.9 | 0 | 3 | 0.69 | Neuropsych 0.74<br>Clin Psych 0.42 |
| **L2** | 3.44 | 9.1 | 9.1 | 1.53 | 3.5 | 2.41 | |
| **AHA** | 0 | 1.5 | 3.9 | 0 | 0 | 0 | |
| **Admin** | 0 | 1 | 1.05<br>0.5 CHSP | 0 | 0 | 0 | 0 |
| **Total supervised** | **3.74** | **15** | **22.5** | **1.74** | **6.5** | **3.1** | |
| | | | | | | | **Total FTE = 60** |

For more detail on department structure and benchmarking to NSLHD, refer to Appendix 3 and for discipline specific organisational charts refer to Appendix 4.

# Key Recommendations:

### Inpatient Rehabilitation Staffing Recommendations

Based on AFRM standards, increase in activity and patient complexity overtime there is evidence to support additional staffing to the IP Rehabilitation wards. The current staffing is based on activity prior to 2014 when the Beachside Rehabilitation Unit (BRU) opened and is not reflective of current activity nor complexity (see Appendix 5 for full analysis of current FTE, benchmarking and comparisons to AFRM standards).

**Current AH staff based on 36 beds compared to AFRM standards**

Based on a case mix of: ARU – 16 reconditioning and restorative; BRU – 20 with case mix of stroke neuro and amputee

**Table 2:**

| | OT | Physio | SP | Clin Psychology | Neuro Psychology | Social Work | N&D | AHA | Podiatry |
|---|---|---|---|---|---|---|---|---|---|
| Total FTE based on AFRM | 4.83 | 5 | 3 | 1.58 | 1.23 | 3.54 | 1.8 | 1.8 | No AFRM standard |
| Current FTE staffing | 4 | 5 | 1.52 | 0 | 0.74 | 2.3 | 1.36 | 3 (2 FTE PT 1 FTE OT) | 0 ** |
| Additional FTE required to meet AFRM standards | 0.83 | 0 | 1.48 | 1.58 | 0.49 | 1.24 | 0.44 | | N/A AFRM Standards(no recommended ratio for Podiatry) |
| Proposed additional FTE and change to staffing | **0.84 L2*** | Conversion of one L2 position to a L3 once a vacancy occurs to provide supervision support (see above) | **0.5 L2 0.5 L3** (see AHA) | **0.63** | **0.42** | **1.0 L3*** | **0.42L3** | **0.5** shared across N&D and SP | **0.21 L2** (for all IP wards) |

**Note:** additional staffing does not bring MVH AH completely to the AFRM standards across AH however it is based on balancing the need for additional staff alongside financial implications. In addition, this data is based on 36 beds however MVH has the capacity to go above this bed number when nursing is fully recruited.

* Includes clinical hours previously reduced due to the creation of HOD position

** 0.21 FTE L3 podiatry funded by PC/GEM for IP wards

**Table 3: Palliative Care and GEM Unit Staffing Recommendations**

| | OT | Physio | SP | Clinical Psych | Neuro Psych | Social Work | N&D |
|---|---|---|---|---|---|---|---|
| Total FTE | 2 | 2.79 | 1.0 Combined with SP HOD – see above | 0.42 | 0 | 1.42 | 1.0 Combined with DT HOD – see above |
| Proposed additional FTE and change to staffing | **0.42 L3** (to support clinical hours lost to L4 TL duties) | **0** | **0.5 L3** to replace 0.5 FTE lost with HOD role | **0** | **0.21 (for GEM)** | **0.5 L3** | **0.5 L3** |

**Table 4: Outpatient and Community Staffing Recommendations**

| | OT | Physio | SP | Social Work | N&D | Podiatry |
|---|---|---|---|---|---|---|
| Current FTE | 5.76 | 6.32 | 0.5 | 1.05 | 1.94 | 1.53 |
| Proposed additional FTE and change to staffing | **0.63 AHA**<br><br>To address extensive referrals and waitlist | **0.5 FTE L3**<br><br>Replacement of part of 1 FTE transitioned to the NBH (inc of 0.21 FTE hands speciality) | **0.42 L3**<br><br>To meet demand and increased complexity | **0** | **0.42 L3**<br><br>To meet demand and increased complexity inc of Diabetes YAC | **0.42 L3**<br><br>To support HOD and OPs. |

## Table A: Total Recommended FTE across Allied Health Service

| | Occ Therapy | Physio | Speech Pathologist | Clinical Psych | Neuro Psych | Social Work | Dietitian | Podiatry |
|---|---|---|---|---|---|---|---|---|
| IP Rehab | 0.84 L2 | 1 FTE L2 to L3 regrade only | 1.0 L3<br>0.5 AHA (with N&D) | 1.0 | 0.42 | 1.0 L3 | 0.42 L3 | 0.21 L3 |
| PC/GEM | 0.42 L3 | 0 | 0.5 L3 | 0 | 0.21 | 0.5 L3 | 0.5 L3 | |
| OPs/ community | 0.63 AHA | 0.5 L3 | 0.42 L3 | 0 | 0 | 0 | 0.42 L3 | 0.42 L3 |
| Total | 0.84 L2<br>0.42 L3<br>0.63 AHA | 0.5 L3<br>1 regrade | 1.92 L3 | 1.0 | 0.63 | 1.5 L3 | 1.13 L3<br>0.5 AHA (to share with DT) | 0.63 L3 |

**Additional:**

- 0.58 HSM 4 (AH manager) – to benchmark with NSLHD sites
- 0.16 Level 6 (Physio HOD) – to benchmark with all other HOD positions across NSLHD

| Total | HSM 4 | Level 6 | Psychology | Level 3 | Level 2 | AHA | Other |
|---|---|---|---|---|---|---|---|
| | 0.58 | 0.16 | 1.63 | 6.11 | 0.84 | 1.13 | 1 FTE PT L3 regrade |

**Comment:**
Depending on approved additional FTE, N&D HOD may require regrade to Level 5 if the FTE supervised exceeds 5 (based on AH award). Option 1 would require regrading however Option 2 does not.

## Funding/ Staffing Options

**Option 1**: As per Table A plus increase FTE of AHM and Physiotherapy HOD to benchmark to like positions across NSLHD.

**Option 2**: Staff to AFRM standards as per Table 2, page 5; replace 0.5 FTE of the 1 FTE physiotherapy outpatient position that transitioned to the NBH; increase FTE of AHM and Physiotherapy HOD to benchmark to like positions across NSLHD.

**Option 3:** Remain ISQ – staff to utilise ongoing control measures (see Appendix 10) to ensure safe workload and consideration to cessation of certain OP services (noting that MVH has been the only site to increase OP activity and provides an area of significant need to the NBs post November 2018).

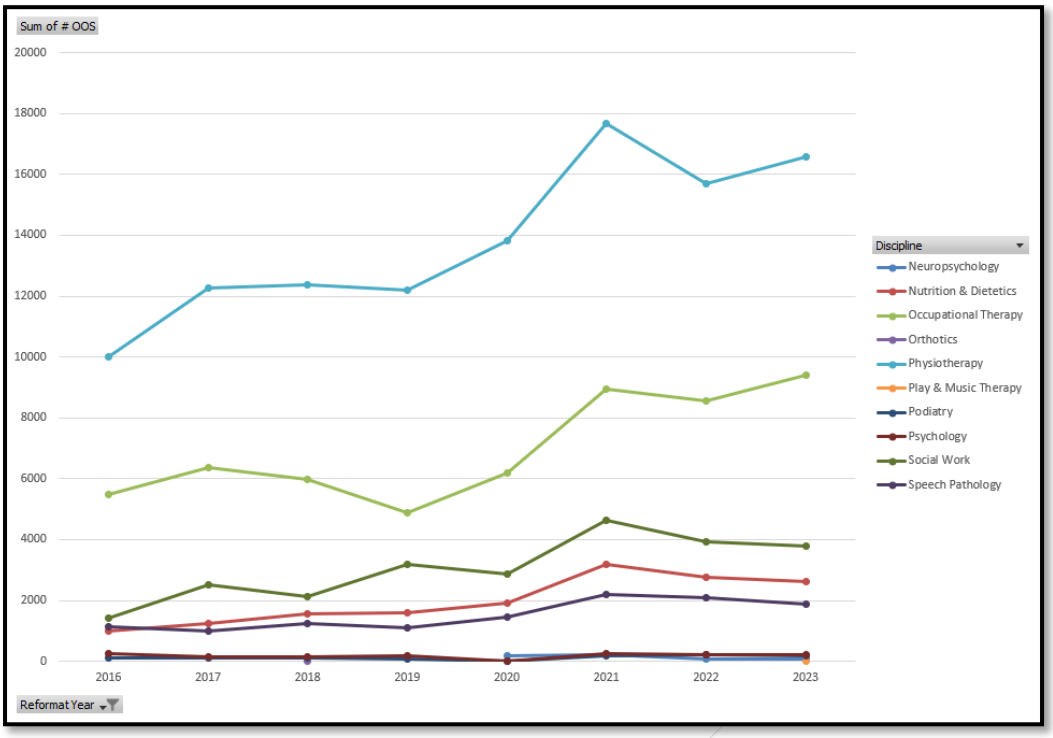
## Summary to Support Recommendations

See Appendix 6 for full data report from NSLHD A/ Allied Health Performance Analyst.

## Overview of Inpatient Statistics

(See Appendix 7 for IP Rehabilitation statistics and Appendix 8 for PC/GEM statistics)

**Total AH Occasions of service (OOS) by Year and Ward – 2016 to current**




The following data has been extracted from the NSLHD Allied Health Dashboard in addition to Cerner Discern Analytics 2.0.

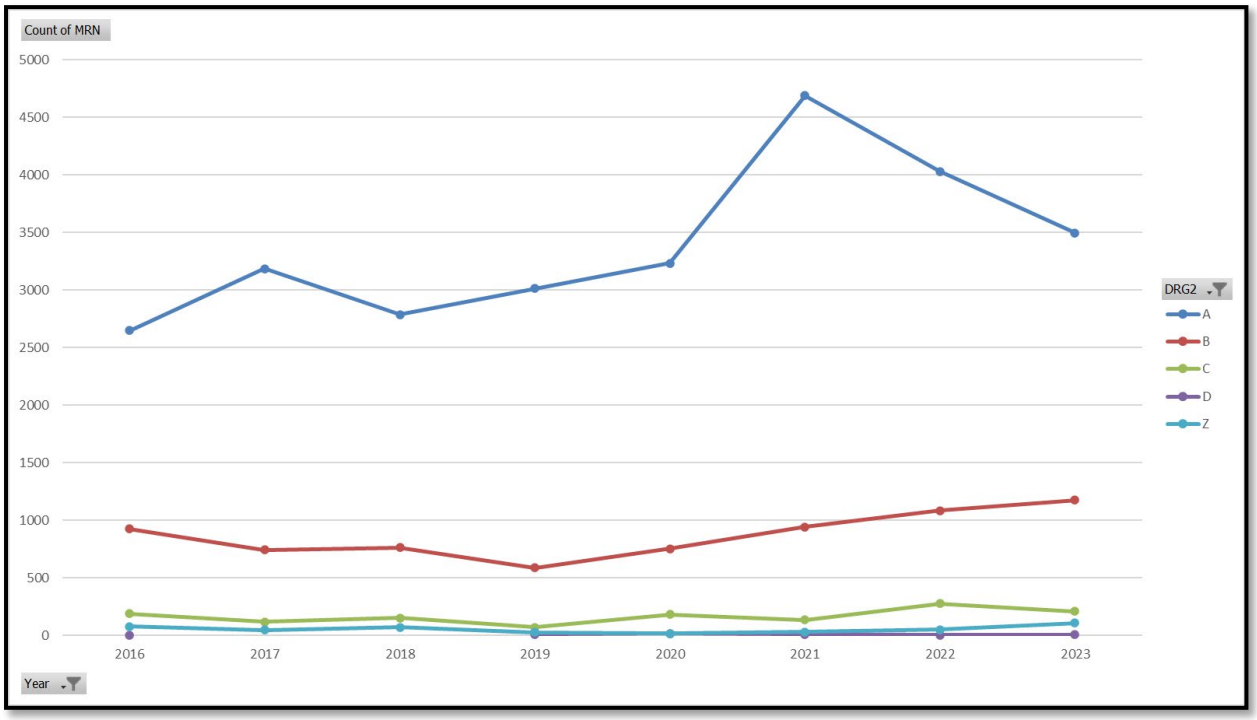
**Comments**:

- This graph contains Service Contact Form data from 2016 to 2023 that has been filtered to ARU, BRU and GEM/ PCU. It does not include any patients seen on the acute wards pre-opening of the NBH in November 2018.
- During the CoVid pandemic, MVH increased their bed base to accommodate some rehab patients from Ryde Hospital.
- During the period from September to October 2021, due to the closure of Arcadia Private Hospital, MVH increased their rehabilitation bed base to 56 with the transfer of AH staffing to assist. This is reflected in the increased OOS for 2021.
- PCU/ GEM opened in February 2022 correlating to an increase in OOS for Some of AH however there has still been an upward trend in activity.

## Overview of Change in Complexity for Inpatients

(See Appendix 6 for full report)

Table: Changing Complexity of Inpatient Rehabilitation Over Time



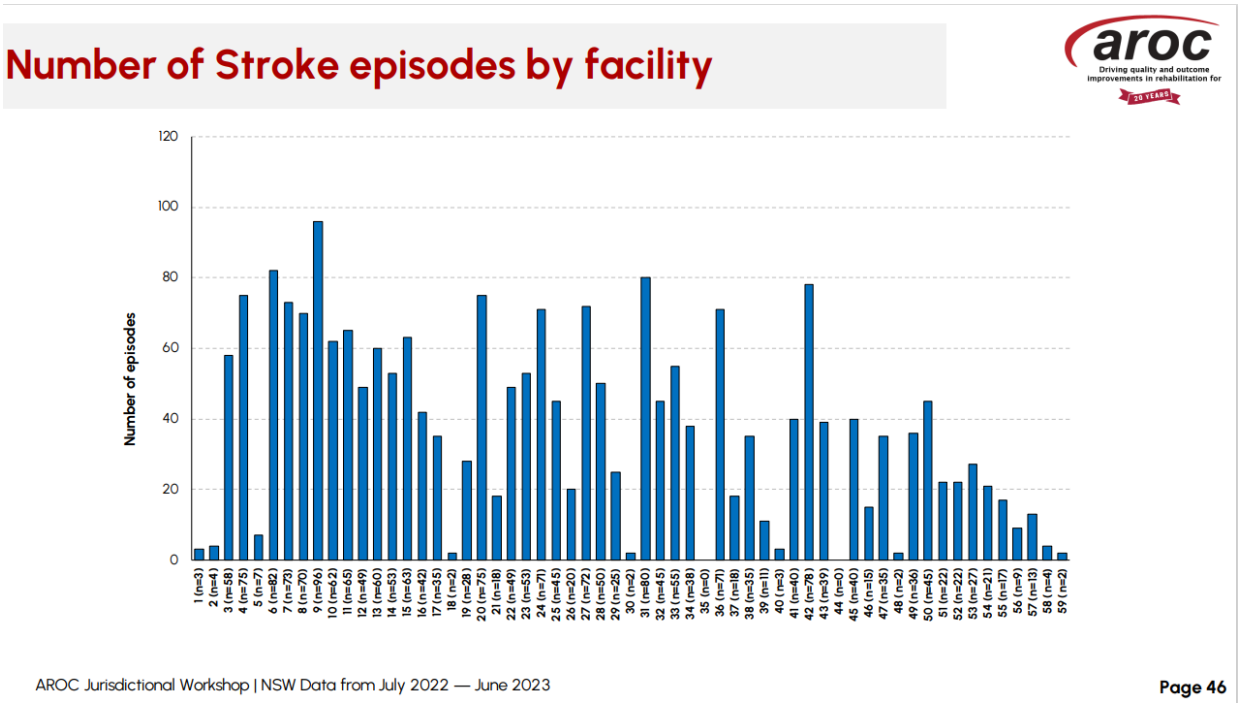

For the purpose of analysis, it has been inferred that patients with a DRG “A” and “B” will be more complex than the other DRGs however it must be noted that DRGs do not explain the whole picture in terms of complexity and subsequent additional AH resources required.

From 2020 to 202 there has been an increase in the number of category A and B patient’s seen by Mona Vale Allied Health. For category A there was an increase of 8.1%, equating to 263 more patients. For category B there was a significant increase of 56.0%, equating to 421 patients more.

It is anecdotally reported that since BRU opened there has been a rise in the number of stroke patients admitted and fewer orthopaedic rehabilitation patients. This is largely due to opening of private rehabilitation facilities on the Northern Beaches that primarily admit more straightforward orthopaedic rehabilitation.

Data from the Australasian Rehabilitation Outcomes Centre (AROC) has shown that MVH is the fifth busiest stroke rehab unit in NSW (see table below). These patients take up significantly more AH time compared to orthopaedic patients especially for disciplines such as SP, N&D and SW. Since 2018, and the opening of additional private rehabilitation capacity on the Northern Beaches, Mona Vale Hospital has experienced an increase in the proportion of stroke rehabilitation patients, as compared with orthopaedic or musculoskeletal rehabilitation patients.

Table: BRU is facility number 20 in this table with 75 episodes of care for FY 2022/23




## Overview of MVH Outpatient and Community Services

MVH AH outpatient services is a growing area of need in the Northern Beaches area that can be demonstrated in the table below where MVH has been the only site to have an increase in non-admitted occasions of service over the last 5 years. This is largely due to the Northern Beaches Hospital providing more interventions requiring AH follow-up on discharge (including more complex surgery) than Manly and Mona Vale Hospitals provided.

In November 2018, MVH AH outpatient and community staff remained at MVH except 1 FTE OP Physiotherapist that transitioned to the NBH to provide OP services however the NBH is not providing OP Physiotherapy for public patients. These patients are being referred to the MVH OP Physiotherapy service to the detriment of patients being referred by GPs who can no longer be accepted due to capacity.

There has also been no additional staffing to account for the additional workload generated by the NBH nor any consideration to the complexity of patients being discharged especially to disciplines such as N&D and SP where the clinician is a Level 2 compared to a level 3 or 4 at the other NSLHD sites.

This table below shows the number of outpatient interaction across the LHD in the last 5 years. From 2019/20 there was a notable reduction in allied health encounters for non-admitted patients compared to 2018/19 largely attributable to the effects of the COVID-19 pandemic. During this time allied health outpatient and community services were impacted through the cancellation of group sessions and staff redeployment to acute services. The table above shows an increase in outpatient activity of 12.2% at MVH compared to a reduction at the other sites There was an increase of 18.4 per cent between 2021/22 and 2022/23 as services began to resume normal operation. This trend is replicated in the breakdown of occasions of service data below for MVH.

**Table: NSLHD AH Non-Admitted Patient Interactions**

| | 2018/19 | 2019/20 | 2020/21 | 2021/22 | 2022/23 | Change (n) | Change (%) |
|---|---|---|---|---|---|---|---|
| MVH | 23,083 | 23,765 | 22,890 | 19,982 | 25,889 | 2,806 | **12.2%** |
| HKH | 33,713 | 29,611 | 26,743 | 26,196 | 31,971 | (1,742) | (5.2%) |
| RNSH | 113,981 | 91,660 | 90,248 | 90,314 | 104,582 | (9,399) | (8.2%) |
| Ryde | 16,683 | 14,393 | 12,969 | 14,104 | 15,880 | (803) | (4.8%) |

*Source NSLHD Report Central Non-Admitted Patients dataset (NBH data not included), accessed 11/09/2023.*

## Psychosocial Impacts on Staff

For full details of the psychosocial hazards reported by the HSU, refer to Appendix 1. Following the WH&S notice, a large body of work has been done to ensure the psychosocial needs of staff are met and to ensure a reasonable workload is in place. A WH&S Risk Plan has been implemented to address the alleged concerns from the HSU (see Appendix 10) and temporary control measures are in place (see Appendix 11) to enable staff to manage their workload. In addition, a workload log recording missed lunch breaks and overtime is monitored regularly and fed back to the monthly meetings between the HSU, MVH Executive and AH HODs. The workplace experiencing the biggest impact on well-being is the IP AH service due to increase in activity and complexity with a workforce established over 10 years ago to reflect a different cohort of patients.

The AH PMES survey for 2023 showed:

- only 40% of staff felt the amount of stress in their job was manageable (down -14% to sector)
- 50% had a favourable sense of well-being (down 22%),
- 25% did not feel burned out (down 3%).

For full details, refer to - MVH PMES 2023 | ND0410805 | Mona Vale - Allied Health

## Appendix 1:

**From:** Blake Adair-Roberts <Blake.Adair-Roberts@hsu.asn.au>
**Sent:** Monday, 24 July 2023 10:35 AM
**To:** Andrew Herning (Northern Sydney LHD) <Andrew.Herning@health.nsw.gov.au>; Kym Morgan <Kym.Morgan@hsu.asn.au>
**Cc:** Mathivanan Sakthivel (Northern Sydney LHD) <Mathivanan.Sakthivel@health.nsw.gov.au>; Melanie Miegel (Northern Sydney LHD) <Melanie.Miegel@health.nsw.gov.au>; Angus Rennie (Northern Sydney LHD) <Angus.Rennie@health.nsw.gov.au>
**Subject:** RE: Allied Health Excess Leave Report Mona Vale Hospital

> Some people who received this message don't often get email from blake.adair-roberts@hsu.asn.au. Learn why this is important

Hi Andrew,

Thank you for your email.

I'm writing in relation to the HSU's concerns over NSLHD's (as the PCBU) suspected breaches of the Work Health Safety Legislation and Regulations which were the basis for our permit entry to Mona Vale Hospital on Thursday 6 July. The HSU writes to notify you of a formal dispute under Division 5, section 80 of the Work Health and Safety Act 2011 (Act) and that the HSU acts as the workers representatives in relation to the dispute.

The HSU requests your engagement as per section 82 (1) of the act to achieve a timely, final, and effective resolution of the issue in accordance with the agreed procedure. We further request that the agreed procedure be the procedure contained in section 23 of the Work Health and Safety Regulations 2017 (Regs).

**Alleged contraventions / issues**

The HSU alleges that the PCBU has breached the following obligations and duties:

1. Section 19 (1) of the Act: primary duty of care to works to effectively manage psychosocial hazards and only where it is not reasonably practicable to do so, mitigate these hazards.
2. Section 17 of the Act: duty to take measures to eliminate the risk and if not reasonably practicable to minimise the risk 'so far as reasonably practicable'. In considering what is reasonably practicable, the PCBU must consider:
    a. The likelihood of psychosocial hazard or risk occurring.
    b. The degree of harm that might result from the hazard or risk.
    c. The availability and suitability of ways to eliminate the hazard or risk.
    d. What the PCBU knows or ought to reasonably know about hazard or risk and the ways of eliminating or managing the risk.
3. Section 47 WHS Act: Duty to consult workers on changes likely to directly impact their health and safety.

**Examples and findings from HSU investigation:**

The HSU has received feedback and input from over 30 workers the Mona Vale facility working in Allied Health Departments, either as clinicians or support staff. The following hazards and subsequent risks have been identified:

The HSU has also received several documents showing minimal attention paid from senior hospital to management to ongoing crises, despite multiple surveys which the HSU have seen showing there is and continues to be a major psychosocial risk emanating from the below hazards.

Hazards:

1. Current staffing levels are not in line with the workload being performed.
2. The case types of the hospital are increasing in complexity and have done so for several years, requiring greater time investment into each patient.
3. No fatigue management plan in place.
4. No workload caps or controls in place to manage workload.
5. No leave cover in place which prevents staff from taking AL entitlement.
6. Community patients wait list is currently 300+, high wait times is leading to greater aggression against staff, including verbal aggression from patient and carers.
7. No workload monitoring or consultation with workforce has occurred in relation to workload management and effective controls.
8. Minimal Allied Health Assistants on staff means that clinicians are required to perform triage and other AHA roles while referrals increase.
9. Changes to the delivery of services in the region around Mona Vale has led to more complex cases and higher referral numbers in recent years.

Available information on risks emanating from hazards:

1. People Matter survey which 49% of staff replied to list the following with the least favourable results:
    a. Burnout (only 28% favourable).
    b. Role clarity – time to perform job (38%).
2. In total over 20 staff across OT, Physio, Dietetics, podiatry, speech pathology and social work departments stated they work unpaid beyond their contracted hours every single day. And additional 4 stated this happened every week. Only 4 out of over 30 said this rarely happens to them.
3. 19 of the staff spoken to say they worked between 3-7 hours of unpaid overtime each week.
4. 17 staff reported that they work through their lunch breaks on a weekly and systemic basis.
5. During interviews with staff the following was expressed:
    a. Across AH Departments:
        i. Inadequate FTE within inpatient teams which is causing increased stress, workload management issues and burn out.
        ii. Staff unable to take leave due to lack of leave coverage being available.
        iii. No clear staffing level model of care provided – in comparison to medical and nursing.
        iv. Significant and potentially unlawful unpaid overtime occurring which is not being monitored by senior management – placing a directive and then allowing workloads to continue building is not sufficient and ignores the PCBU's positive obligation.
        v. Lack of temporary support staff comparative to nursing and medical.
        vi. The changes to NBH structure which converted senior clinicians to managers without adequate replacement, causing junior staff to take on more complex and challenging cases.
        vii. Despite evidence of ongoing briefs being provided to senior management for new FTE, these are consistently denied. Making it clear the Hospital is aware of the staffing issues but makes continued efforts to block genuine controls, despite them being reasonably practicable.

b. Dietetics:
    i. Work occurs beyond contracted hours and lunch breaks daily.
    ii. Inadequate staffing for Pall care / GEM which requires rehab dietitians to assist, compounding issues within rehab.
    iii. YAC established and dietetics contained in model of care, but no funding established for this.
    iv. Stress leave has occurred in department based on demands of current outpatient services.
    v. Increasing waitlist for outpatient services and increasing complexity is requiring longer appointment times and more frequent reviews.
    vi. Despite survey results no changes made from Hospital management level.
c. Podiatry:
    i. Department has no back fill for unplanned or planned leave.
    ii. Service referrals for entire hospital and northern beaches with only 3 staff leading to back-to-back appointments each day.
    iii. Administrative workload unable to be filled in work time.
    iv. Podiatry manager role is 1 FTE but reports to two different GMs across different hospitals with different governance and responsibility for 2 separate reporting lines to 2 major hospital outpatients clinical: Hornsby MDT high risk foot service, inpatient services at Mona and Hornsby including renal dialysis service and 6 community clinics.
    v. Total FTE is split across PT roles at MVH amounting to only 1.53 for community and 0.21 for inpatients.
d. Occupational therapy:
    i. Staff have been unable to take more than a handful of AL days for the last 12 months.
    ii. Common for AL requests to be rejected because of staffing constraints.
    iii. Complexity of patients attending OT has increased significantly – leading to a mismatch between complexity of cases and FTE required.
    iv. Staff are working on weekends to ensure handover of administrative work can take place during the week.
    v. Admin support for OT is servicing a waitlist 300+ long, meaning a 7 month wait and 11 months wait for cat 2 /3.
    vi. Current workload is equivalent to 1.5 FTE and experiencing significant verbal aggression from patients.
    vii. Community OT:
        1. Only 2 FTE managing above 300+ wait list with at least 10 referrals a week.
        2. No AHA to assist with triage.
e. Physiotherapists:
    i. Use of dual managerial and clinical roles create challenges for managing competing duties. TL's being required to perform TL duties 5 days a week while only being paid for 2 days.
    ii. No relief cover or backfill available for team.
    iii. Increasing meetings and committees puts more pressure on workloads and clinical obligations, resulting in more unpaid work out of hours or through lunchbreaks.
f. Social Work:
    i. Half management / half clinical structure reduces the ability to service both areas.
    ii. Covering AYAH as well reduces capacity, but patient referrals continue to increase.

iii. Increasing workload associated with NDIS and complex neuro patients.
iv. High unpaid overtime being performed.

g. Neuropsychology
   i. Reduction in FTE from 1 to 0.7.
   ii. Complexity of patients means referrals take a very long time (up to 10 hours once report writing considered).
   iii. Reduces capacity for adequate supervision (Award requirement) and must be done in own time.
   iv. No consultation on staffing levels upon addition of two new units / services open under MVH umbrella (pall care and AYAH), no new staffing for these additional services.

h. Speech Pathology
   i. Junior staff being required to work on cases beyond skill or safety level due to loss of senior clinical staff when acute services moved to NBH. Lack of WHS specific consultation on this change.
   ii. Inpatient staffing levels as per above.
   iii. Leave coverage as per above.
   iv. Changing complexity levels which have not been consulted in relation to the level and training of staff provided.
   v. Increasing administrative duties to lack of administrative support leading to unpaid overtime and burn out.

6. Departmental leadership (HoDs) and AH leadership have tried to establish casual pools and put into place informal workload management however have had minimal support from hospital management.
7. During PE inspection, the HSU were advised there was no fatigue management plan or workload management caps for Allied Health, despite this being in place for nursing and medical.
8. MVH Allied Health outputs to target showed that all groups except physio had failed to meet their targets by a significant amount. Physio it was noted had met targets due to exercise groups.

**Controls to eliminate hazards, or if not reasonably practicable, minimise risk.**

In failing to develop fatigue management, leave coverage and workload management strategies which protect staff the PCBU has failed to identify hazards (s 34, Regs). The PCBU must immediately consult with workers and their representatives being the HSU to develop controls to eliminate these hazards now they are identified.

In relation to the workload, unpaid overtime, and ongoing burnout, the PCBU must, in accordance with s 35 of the Regs, (a) eliminate risks to health and safety, and (b) if it is not reasonably practicable to eliminate – minimise those risks as far as reasonably practicable.

As per section 55C of the Regs, the PCBU must manage psychosocial risks in accordance with clause 36 of the regs. Section 55D provides further obligations to eliminate, minimise psychosocial risk, and provides all the relevant considerations the PCBU must have regard to.

The HSU points to (a)-(d) as providing ample support for strong controls based on the ongoing duration, lack of action so far, severity and exposure, the cumulative impacts of each hazard, the escalating job demands and the system of work including how its managed and supported.

<u>Controls:</u>

1. Immediately increase staffing levels across Departments to ensure that ratios are in place between Allied Health and staffing in accordance with safe guidelines, staff have leave coverage and unpaid overtime is no longer common practice. The HSU requests as a minimum control AFRM standards with further discussions continuing as to whether this is sufficient.
2. Immediately place a cap on total beds and referrals until such time as the staffing levels can meet the demand.

As per the default dispute procedure contained in the Regs, we request a meeting with you as soon as possible to discuss the details and implementation of the above controls.

**Please provide a written response and confirmation of intention to hold discussions with the HSU by COB Friday 28 July.**

Regards

Blake Adair-Roberts | Division Secretary, Allied Health
Health Services Union NSW/ACT/QLD
Level 2, 109 Pitt Street Sydney NSW 2000
Tel: 1300478679 Mob: 0438 944 966

## Appendix 2: AH WH&S Risk Management Plan

20230914 - Allied Health WHS Risk Management Plan v0 (007).zip

## Appendix 3: Department Structures and Benchmarking to NSLHD Sites

**Note:** Due to the significant differences between RNSH and MVH sites and staffing profiles, comparisons have not been made to RNSH except in the cases of Rehab & Aged Care AH OP and Community Services and Podiatry.

**HSM 4 Allied Health Manager – 0.42 FTE:**

- This position is part of the MVH Executive and reports to the MVH General Manager. The Heads of Departments (HODs) report directly to the AH Manager as well as the Neuro and Clinical Psychologists. See page 4 for Organisational Chart.
- It is responsible for 60 FTE including the Rehab & Aged Care AH services which encompasses the CHSP service. Ryde and RNSH have a 1 FTE AH Manager for their Community Aged Care & Rehab (CARES) AH services additional to their 1 FTE overall AH Managers.
- MVH RACS AH Team comprises of 14.55 FTE and the overall management of the CHSP component of this service is managed by the 0.42FTE AH Manager. The management of CHSP is a significant workload largely due to large % of MVH RACS AH staff funded by CHSP.

**Duties:**

- Leadership to AH as part of the executive team to support, mentor and develop staff (AH HODs have largely become leaders due to changes in MVH structure in 2018 rather than through career leadership development and promotion)
- Advice to MVH and NSLHD on issues pertaining to AH.
- Attendance at site and LHD meetings as executive lead for MVH Allied Health – approximately 8 hours of the 16 hours a week is spent in meeting attendance. A body of work was done in mid-2023 to reduce this from 12 to 8 hours.
- Service evaluation and development
- Management of the Community Home Support Program (CHSP) AH service and the managerial/ administrative obligations that comes with this MOH funding.

**Benchmarking:**

- MVH does not have a separate RACS manager and the AH services report to the O.42 FTE AH manager – this team comprises of 14.6 FTE.
- Ryde has a 1 FTE AH Manager and a 1 FTE level 5 Community Aged Care & Rehab Service (CARES) Manager for 7.39 AH FTE. This position has recently been realigned to acknowledge the increased managerial requirements of the position and holds a small clinical load.
- RNSH has a 1 FTE AH Manager and a 1 FTE HSM 3 CARES Manager and is operationally responsible for 8.9 FTE AH and 7.89 Older Persons Mental Health Team.

**Recommendation:**
Increase FTE to 1 FTE to support the duties of this role including executive representation, support to 60 FTE including direct report to the MVH AH HODs and Psychology Team, management and coordination of the outpatient and community service including CHSP services, adherence to the NSWH outpatient framework and CHOC data compliance

**Level 4 Nutrition and Dietetics Head of Department- 0.63 FTE:**

- This position is currently a 1 FTE job share position at 0.5FTE each and carries approximately a 35% clinical load. The managerial load for this position has increased with the opening of PC/GEM and AYAH with reduction in clinical hours -in 2019/20 the clinical load was 48%.
  Consequently, clinical support to the Level 1/ 2s is provided by the HOD. The position supervises the OP and Community DT service including CHSP staff.
- In Nov 2018 the existing N&D HOD position became void ( the affected staff member did not transition to the NBH). At this point the most senior remaining clinicians (both Level 3 personal regrades) became the department lead. Both had full clinical loads prior to this point in time. A large % of these clinical hours became managerial.
- No loss of clinical hours have been replaced.
- Provides a clinical caseload to PC/GEM and the 1 FTE PC/GEM funded position incorporates the HOD role. To support the clinical case load to these units, staffing is utilised from existing IP rehab staff.

**Comparisons:**
- MVH L4 HOD position supervises 3.74 FTE across IP rehab, PC/GEM, AYAH, and outpatients. The only position above a Level 1/2 is the positional AYAH 0.32 FTE Level 3.
- The HKH 1 FTE Level 5 HOD supervises 10 FTE and has no clinical load – this includes a 1 FTE deputy (who has approximately a 30% clinical caseload) and 2.4 FTE L3 senior clinical dietitians that provide support to the Level 1/2s.
- The Ryde 1 FTE Level 5 HOD position operationally supervises 5.26 FTE inclusive of 0.21FTE leave relief (and 4.92 FTE professional reports) with 1.26FTE of level 3 senior clinical support. The HOD has a very minimal clinical caseload and manages no OP and community staff.

## Recommendations:
- Backfill of lost clinical hours and establishment of a Level 3 Senior position at 0.5 FTE to support the development of junior staff and create career development opportunities within the department (to be part of recommended IP staffing)..

**Level 6 Occupational Therapy Head of Department – 0.84 FTE:**

- The current OT HOD is on a TIRA working at 0.84FTE and is backfilled clinically at 0.16 FTE (however this backfill has been unable to be recruited to).
- Prior to November 2018 the person in this role was the OT Team Leader, second in line to the OT HOD position which transitioned to the NBH. This role had an approximate 70% clinical caseload within IP rehabilitation. Conversion of this position to OT HOD resulted in a reduction of approximately 0.5 FTE clinical support to IP rehabilitation.
- No loss of clinical hours have been replaced.
- Provides leadership to 14 FTE across IP rehab, PC/GEM, AYAH, and outpatients CHSP service. Services provided at MVCHC and BCHC.

**Level 4 Occupational Therapy Inpatient Team Leader – 1 FTE**

- This position was regraded form a Level 3 Senior to a Level 4 TL due to the increasing staff associated with PCU, GEM and AYAH. The successful candidate for the TL role was the L3in PCU/ GEM. This appointment did not affect the L3 Senior in IP rehabilitation meaning that there is still a senior clinician to support the L1/2s (see below for Physiotherapy).

**Benchmarking:**

- HOD supervises 14 FTE and has approximately a 15% clinical load. The department has an IP 1 FTE Level 4 Team leader, IP 1 FTE L3 Rehabilitation Senior and1 FTE L3 OP/ community Senior. The AYAH 0.42FTE is a positional L3 Senior. The HOD supervises the OP and community OTs including CHSP staff.
- HKH Level 6 HOD supervises 23 FTE with no clinical load- this includes a 1 FTE Level 4 deputy/ acute Senior (? clinical load) and 8 FTE level 3 Seniors.
- Ryde 1 FTE Level 5 HOD supervises 13.7 FTE (? clinical load) – this includes a 1 FTE Level 4 and 2 FTE Level 3 seniors. The HOD does not manage the OP and community OT staff.

- **Recommendation:** replacement of lost clinical hours to IP rehabilitation (see additional staffing for AFRM standards).

**Level 6 Physiotherapy Head of Department - 0.84 FTE:**

- The current PT HOD position is a job share 0.42FTE each, with one of the HODs also covering the 0.42 FTE AH Manager position.

- Prior to the November 2018 this position was the Physiotherapy Team Leader responsible for IP rehab and outpatient and community services including hydrotherapy. This position had an approximate 0.21 FTE clinical load in the OP Rehabilitation and Aged Care Service (RACS). This clinical load had reduced over a period of 5 years as the position took on more services under its portfolio but was initially approximately a 0.5FTE clinical. This position now carries no clinical caseload.

- No loss of clinical hours have been replaced.

- Provides leadership to 22.5 FTE across IP rehab, PC/GEM, AYAH, Urgent Care Centre (UCC) and Musculoskeletal outpatients - including a specialised Women's Health service, Hands service, hydrotherapy and CHSP service. Services provided at MVCHC and BCHC. The position has no clinical load.

**Level 4 Physiotherapy Inpatient Team Leader – 1 FTE:**

- This position was regraded from a level 3 Senior to a Level 4 TL due to the increasing staff associated with PCU, GEM and AYAH. The successful candidate for the TL role was the L3 Senior clinician. This appointment resulted in the loss of the senior clinical support to the 4FTE Level 1/2s in IP rehabilitation. There is a Level 3 in PCU and GEM.

**Benchmarking:**

- MVH PT HOD manages 22.5 FTE including 1.47 FTE Positional Level 4 Primary Contact Physiotherapists in the Urgent Care Centre (UCC), Level 4 IP Team Leader, 1 FTE OP Senior,0.63 FTE Level 3 RACS Senior and 3.9 FTE Positional Level 3 positions (Hands, Women's Health, Palliative care, AYAH). There is no IP level 3 senior for IP Rehabilitation.

- HKH 1 FTE Level 7 position supervises 37 FTE and has no clinical load. The department has a 1 FTE Level 5 Deputy, 4 FTE Level 4 Team Leaders, 2.84 FTE clinical Level 4 positions, 4.2 FTE Level 3 Seniors and 2.7 FTE clinical L3 positions.
- Ryde 1 FTE Level 7 position supervises 23.1 FTE and has a small clinical load. The position is supported by a 1 FTE each level 4 and level 5 Team Leader for IP acute and IP rehab and 3 FTE Level 3 ward seniors. The position does not supervise RACS outpatient and community PT staff.

**Recommendations:**

- Additional 0.16 FTE to the Level 6 PT HOD position to make this position 1 FTE (as per every other AH HOD position across the LHD).
- Regrade of one of the current IP L1/2 positions to a level 3 IP Senior
- Additional 0.5 FTE to replace the 1 FTE that transitioned to the Northern Beaches Hospital (NBH) – see below.

**Level 4 Podiatry Head of Department – 0.5 FTE:**

- The current 1 FTE Podiatry HOD works as the manager to both MVH and HKH Podiatry services. Although MVH funds 0.5FTE of this position, the caseload at HKH supports twice as many FTE and CHC clinics and hence takes up twice as much of the 1 FTE.
- In 2020 it was noted that MVH was funding 0.7 FTE of the position and this was amended to 0.5 FTE with no return in funding to the MVH podiatry department.
- The MVH HOD position was established in 2010 with funding taken from clinical hours which have not been replaced.
- This position carries no regular clinical load at MVH
- Provides leadership to 1.74 FTE across MVH inpatients, outpatients to the MVCHC and BCHC

**Benchmarking:**

- 1 FTE Level 5 Podiatry HOD position manages staff at both MVH and HKH. It is the only MVH AH position to supervise across two hospitals. The MVH part of the role supervises 1.74 FTE and HKH part supervises 4.23 FTE (plus 0.21 orthotist and 0.11 AHA) and manages podiatry services across the 2 hospital sites and 6 Community Health Centres (CHC). There is no deputy position, and the Level 3 seniors are predominantly clinical. MVH has 0.21FTE and HKH has 3.1FTE Level 3.
- RNSH/ Ryde 1 FTE Level 5 HOD supervises 5.73 FTE which incorporates 0.63 FTE Level 4 and 1.79 FTE Level 3. The podiatry department was the only AH discipline to remain cross site when RNS and Ryde Hospitals separated last year. The HOD does not manage OP/ community (CHSP) staff.

**Benchmarking to SESLHD:**

- The Podiatry Manager for SESLHD is classified as a Level 8 Podiatry Advisor however the managerial component of this position manages 2.58 FTE at St George Hospital and 4.83 FTE (inclusive of 3.55 CHSP FTE) at Sutherland Hospital. This managerial load is comparable to MVH/HKH. Feedback from the Podiatry Advisor is that the workload is manageable with delegation to newly created senior positions.

**Recommendations:**

- Additional 0.63 FTE Level 3 operational Senior to assist the HOD in clinical and operational support and provide assistance to IPs/OPs (see below).
- Consideration was made around separating the MVH/ HKH HOD position however this review does not support this as being in the best interest of the department overall due to …

**Level 5 Social Work Head of Department – 1 FTE:**

- The current SW HOD is on a TIRA working at 0.79FTE and is backfilled clinically at a Level 0.21 FTE. At full-time this role carries approximately a 40% clinical caseload primarily in IP rehabilitation.
- Prior to November 2018, this person held a 1 FTE Level 3 senior clinical caseload within IP rehabilitation. This has resulted in a loss of approximate 0.5 FTE clinical hours to IP rehabilitation and the loss of the senior clinical support to this team. This does not include any clinical support the SW HOD may have provided to IP rehabilitation pre-November 2018 as this position held a clinical load across the MVH site.
- No loss of clinical hours have been replaced.

**Benchmarking:**

- MVH 1 FTE Level 5 HOD supervises 6.5 FTE across IP rehab, PC/GEM, AYAH, outpatients and community at the MVCHC and BCHC including a CHSP service. The position has approximately a 40% clinical load in IP rehab. The department has 3 FTE clinical Level 3 positions in PCU and AYAH. There is no IP Level 3 Senior in IP rehab and Level 1/2 clinical supervision is provided by the HOD.
- HKH 1 FTE Level 6 HOD has a very small clinical load and supervises 15.5 FTE and is supported by a 1 FTE Level 4 deputy who has approximately a 50% clinical load and 6 FTE Level 3 Seniors.
- Ryde 1 FTE Level 5 HOD supervises 7.5 FTE and is supported by 1 FTE Level 3 Team Leader for IP rehabilitation and 1 FTE for acute wards and 0.42 clinical level 3 for PC. The HOD does not manage the OP and community OT staff.

**Recommendation:**

- Additional 0.5 FTE Level 3 to replace lost senior clinical hours in rehabilitation for supervision and career development (see additional staffing for AFRM standards).

**Level 4 Speech Pathology Manager – 1 FTE:**

- The current SP HOD is on a TIRA working at 0.79FTE and is backfilled clinically at a Level 0.21 FTE. This role carries approximately an approximate 50% clinical caseload.
- Prior to November 2018, this person held a full-time level 3 senior clinical caseload within IP rehabilitation. This has resulted in a loss of approximate 0.3 FTE clinical hours to IP rehabilitation and the loss of the senior clinical support to this team.
- No loss of clinical hours have been replaced.
- The HOD position carries a clinical caseload in PC/GEM.

**Benchmarking:**

- MVH 1 FTE Level 4 HOD supervises 3.1 FTE and has approximately a 50% clinical caseload. The department has 0.6 9FTE Positional Level 3 for the AYAH and the vidieofluoroscopy clinic. The HOD provides clinical supervision to the Level 1 / 2s.
- HKH 1 FTE Level 5 HOD supervises 8.5 FTE and has no clinical .This position is supported by 1 FTE Level 4 and 2 FTE Level 3 Seniors.
- Ryde 1 FTE Level 4 HOD supervises 4.72 FTE .The position is supported by 1.69 FTE L3 Seniors to IP rehabilitation and acute. The HOD does not manage any OP and community staff.

**Recommendations:**

- Additional 0.3 FTE Level 3 to replace lost clinical hours and support IPs (see additional staffing for AFRM standards).

**Psychology**

- MVH has 0.74 FTE (2 headcount) Neuropsychology and 1.05 FTE Clinical Psychology (2 headcount) who operational report to the MVH AH Manager.
- Ryde Neuro and Clinical Psychologists report to the Director of Medical Services.
- HKH Neuro and Clinical psychologists report to the AH Manager
- RNSH Clinical and Neuropsychologists report to the medical divisions.

**Recommendation:**

- Increase in FTE of the MVH AH manager position to support the operational management of this service.
- Reinstatement of 0.26FTE Neuropsychology (see below)
- 0.63 FTE Clinical psychology IP rehabilitation (AFRM standards – see below)

## Appendix 4: MVH Allied Health Organisational Charts

MVH AH Organisational Charts jan 2024 - deidentified.zip

## Appendix 5: Overview of FTE to IP Rehabilitation

AFRM standards are the benchmark on which Inpatient Rehabilitation Services base their staffing. The staff establishment for a rehabilitation medicine service includes an adequate number of professional and support staff to allow the service to provide contemporary, evidence-based rehabilitation management in a safe, effective and efficient manner.

Link to AFRM Standards document: https://www.racp.edu.au/docs/default-source/advocacy-library/afrm-standards-for-the-provision-of-inpatient-adult-rehabilitation-medicine-services-in-public-and-private-hospitals.pdf?sfvrsn=4690171a_4

The AFRM standards set out ratios for AH staff to patient numbers. There are variances in this ratio for the type of complexity of patients e.g. stroke patients attract a higher AH ratio than reconditioning.

**AFRM standards for AH Staff to Patient ratios for each 10 Inpatients:**

| | Occ Therapy | Physio | Speech pathologist | Clinical Psych | Neuro Psych | Social Work | Dietitian |
|---|---|---|---|---|---|---|---|
| Amputation | 1 | 1.5 | consult | 0.5 | consult | 0.6 | 0.4 |
| Stroke/ Neurology | 1.5 | 1.5 | 1.5 | 0.5 | 0.5 | 1.0 | 0.5 |
| Orthopaedic | 0.8 | 1.25 | 0.1 | 0.2 | consult | 0.5 | 0.4 |
| Major Trauma | 1.2 | 1.5 | 0.2 | 0.4 | 0.5 | 1.0 | 0.6 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Spinal Cord Dysfunction | 2 | 2 | 0.25 | 0.5 | 0.3 | 1.2 | 0.4 |
| Traumatic Brain Injury | 1.5 | 1.5 | 1.5 | 0.8 | 0.8 | 1.2 | 0.5 |
| Reconditioning & restorative | 1.2 | 1.25 | 0.2 | 0.4 | 0.2 | 1.0 | 0.5 |

A comparison of MVH AH staffing to AFRM standards has been undertaken for 36 IP rehabilitation beds, which is the current bed numbers based on nursing levels due to unfilled positions. The facility has the capacity to increase to 56 beds but on full nursing staffing has been running at 40 beds over the last few years.
Staffing is based on a case mix of from in March 2022 when there was a bed occupancy of 39:

- ARU – 16 beds – reconditioning and restorative
- BRU – 23 beds – stroke (12), neuro (7), amputees (2) other (2)

**It should be noted** that if AH is staffed for 36 beds as per the AFRM standards and the bed numbers increase over 36, then AH staffing will again be below these standards.

These standards do not take into account ratios of junior to senior staffing. Due to the loss of AH senior positions over time, as discussed earlier in this paper, the proposed additional staffing take into account this.
**Benchmarking to NSLHD:**

**Graythwaite –** based on current 48 beds, 50% reconditioning, pain 30% neuro, stroke and 20% orthopaedic and amputation (initially staffed for 64 beds ).

| | OT | Physio | SP | Psych | Neuro Psych | Social Work | N&D | AHA | Orthotics | Podiatry |
|---|---|---|---|---|---|---|---|---|---|---|
| Current staffing | 6.63 | 7.5 | 2.9 | 0.8 | 0.8 | 4.42 | 2.94 | 8.84 | 0.4 | 0.53 |
| Total based on AFRM | 5.1 | 5.65 | 2.4 | 1.9 | 1.3 | 3.9 | 2.3 | 2.4 | | |

TL Level 5 PT; TL Level 4 OT; Level 3 in PT, OT, SP, orthotics and podiatry

**HKH Rehab-** 28 beds based on 50% reconditioning, 30% ortho and 20% stroke

| | OT | Physio | SP | Clin Pysch | Neuro Psych | Social Work | N&D | AHA | Orthotics | Podiatry |
|---|---|---|---|---|---|---|---|---|---|---|
| Current staffing | 2.63 | 4 | 1.2 | 0.5 | 0 | 2.18 | 0.71 | 2.3 | 0 | 0 |
| Total based on AFRM | 3.37 | 3.8 | 1.69 | 1.07 | 0.41 | 2.5 | 1.35 | 1.4 | | |

## Appendix 6: NSLHD A/ Allied Health Performance Analysis data report

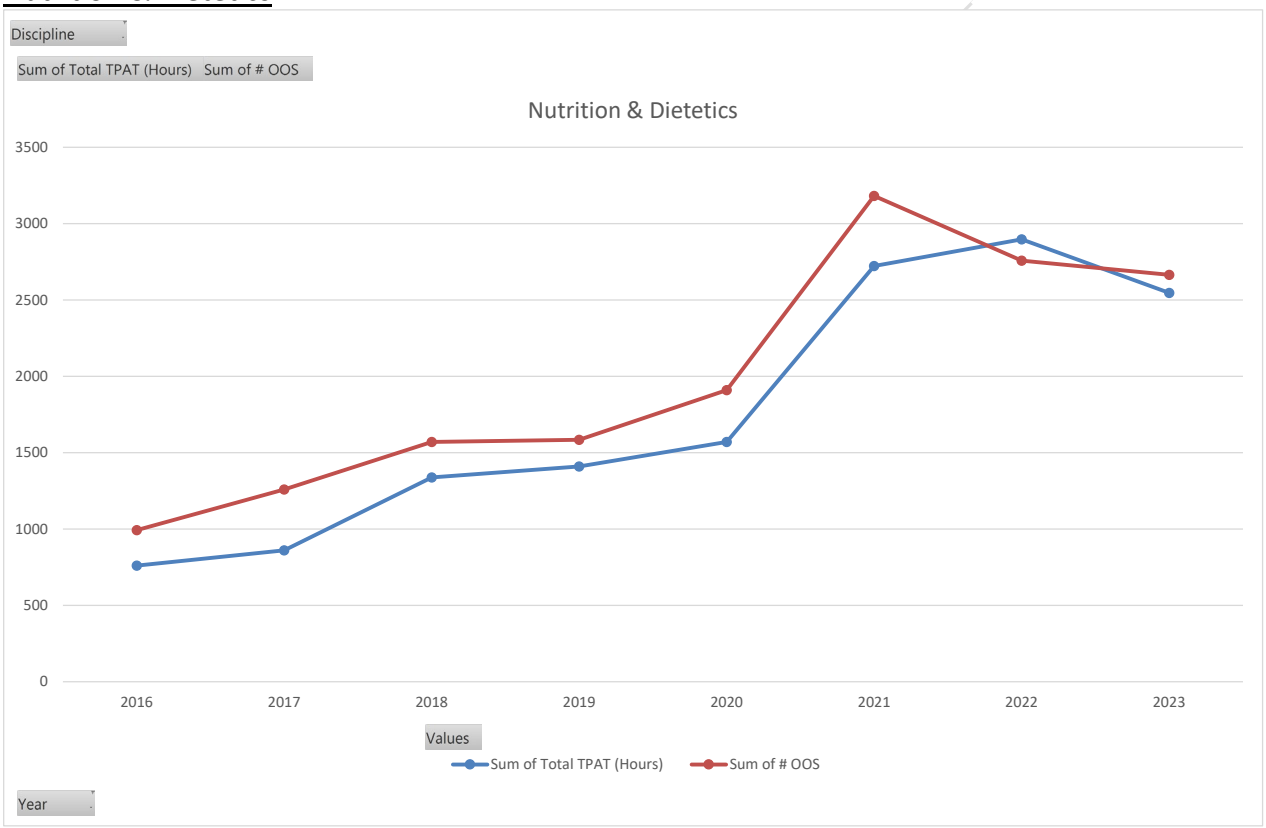
MVH Analysis (002) Kat's report.zip

## Appendix 7: Statistical Breakdown of Individual AH Discipline Activity

**Mona Vale Hospital Discipline Breakdown.**
**Data provided by A/Allied Health Performance Analyst**

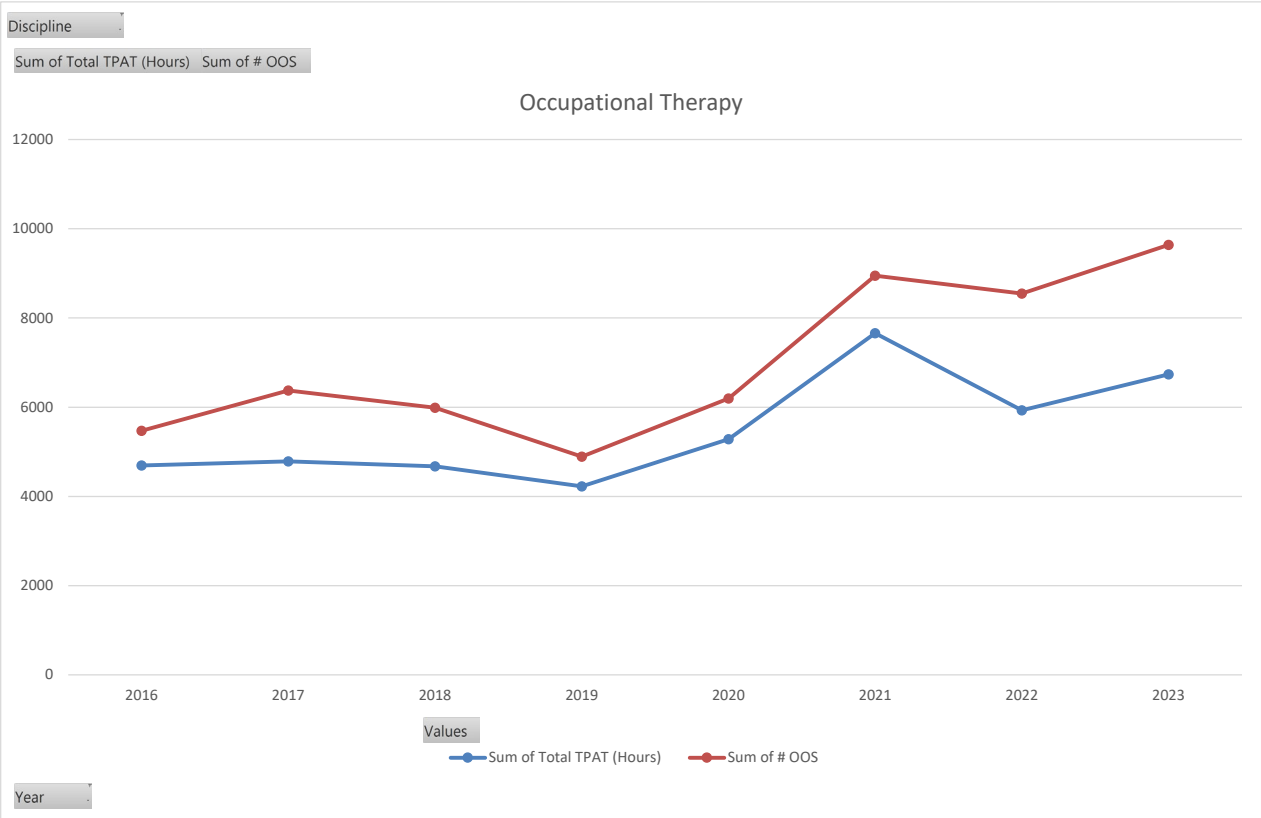
This data includes Admitted Patient activity from the Assessment & Rehabilitation Unit, Beachside Rehabilitation Unit, and GEM wards and is sourced from the Allied Health Dashboard. It compares the occasions of service (OOS) and overall total patient attributable time (TPAT) from 2016 to 2023 by discipline.

Nutrition & Dietetics



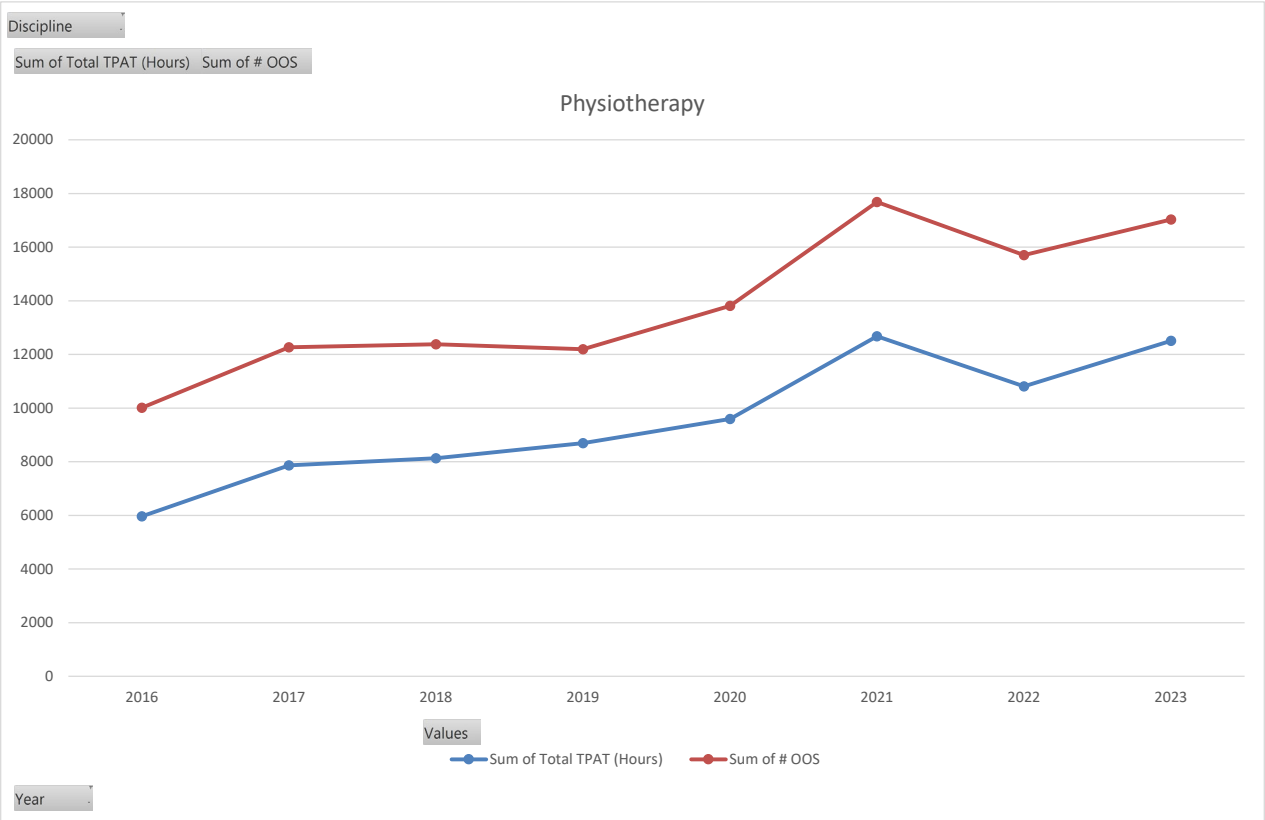

There has been an increase in both OOS and TPAT from 2016 to 2023. Most of this increase occurred between 2016 to 2021 and there has been a slight decline in both metrics from 2021 to 2023 with some variance in TPAT compared to OOS.

## Occupational Therapy



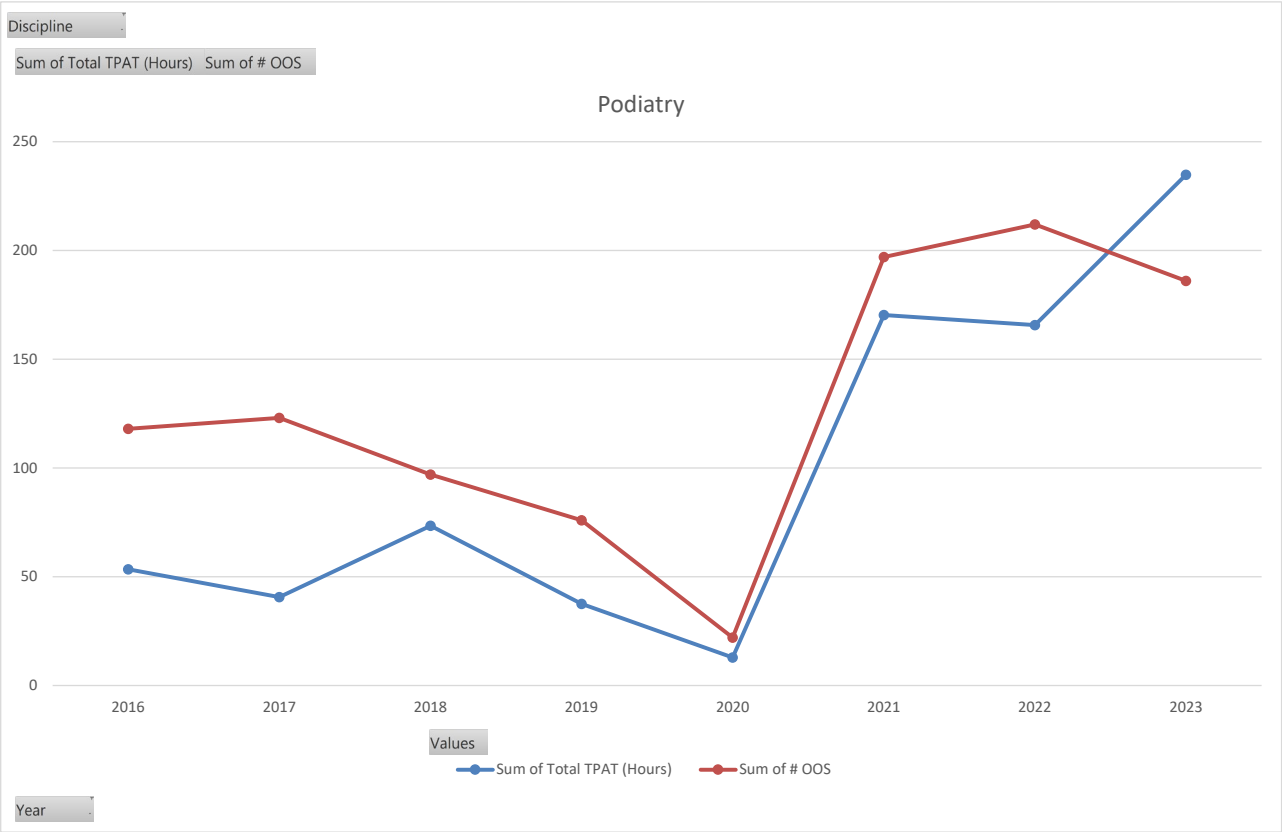

There has been an increase in both OOS and TPAT from 2016 to 2023. Most of this increase occurred between 2016 to 2021 and there has been a slight decline in TPAT and slight increase in OOS from 2021 to 2023. From 2021 to 2023 there has been a larger discrepancy between total OOS and TPAT suggesting that whilst more there is more client activity there has not been more time spent providing care in this period.

## Physiotherapy




There has been an increase in both OOS and TPAT from 2016 to 2023, with small decrease in OOS between 2021 and 2023, whilst TPAT remained at a similar level.

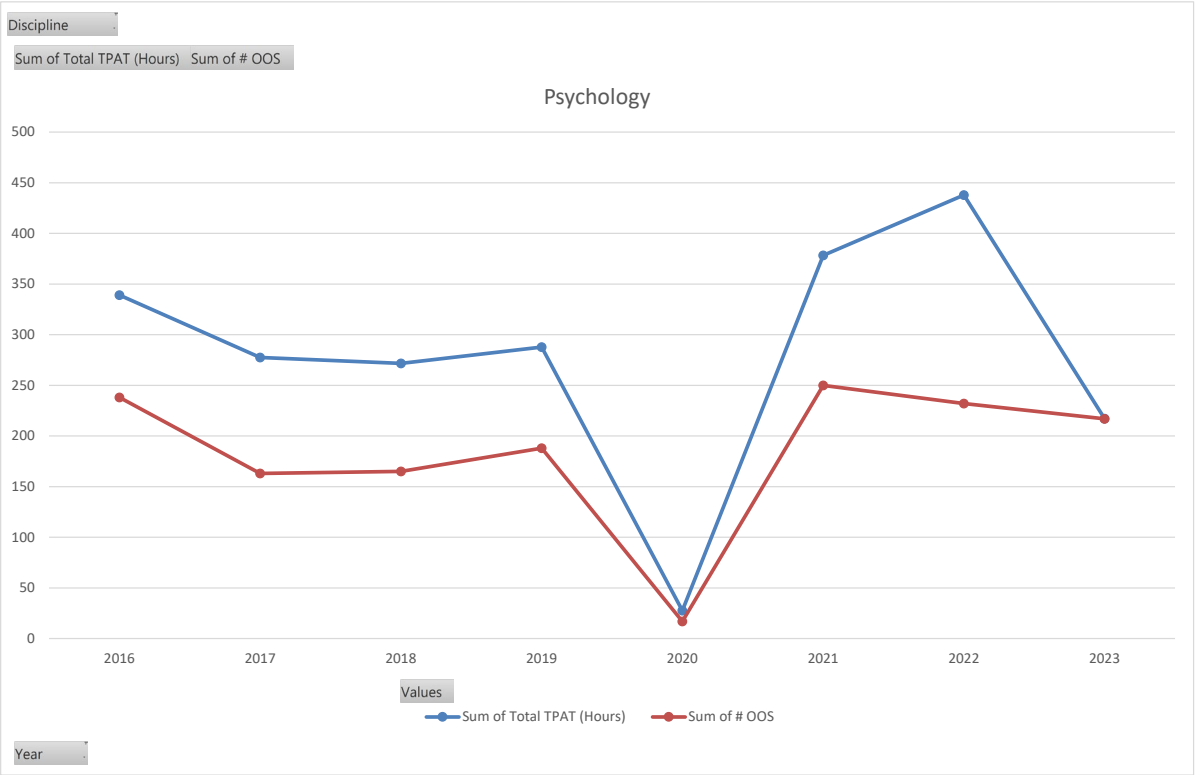
## Podiatry




From 2016 to 2020 there is a steady decline in Podiatry OOS with varied decline in the associated TPAT. There is then a large increase in both TPAT and OOS from 2021 onwards, with slight decrease in 2023 OOS. Of note there is a large disparity between TPAT and OOS in 2023, suggesting each OOS took a larger amount of clinician time.

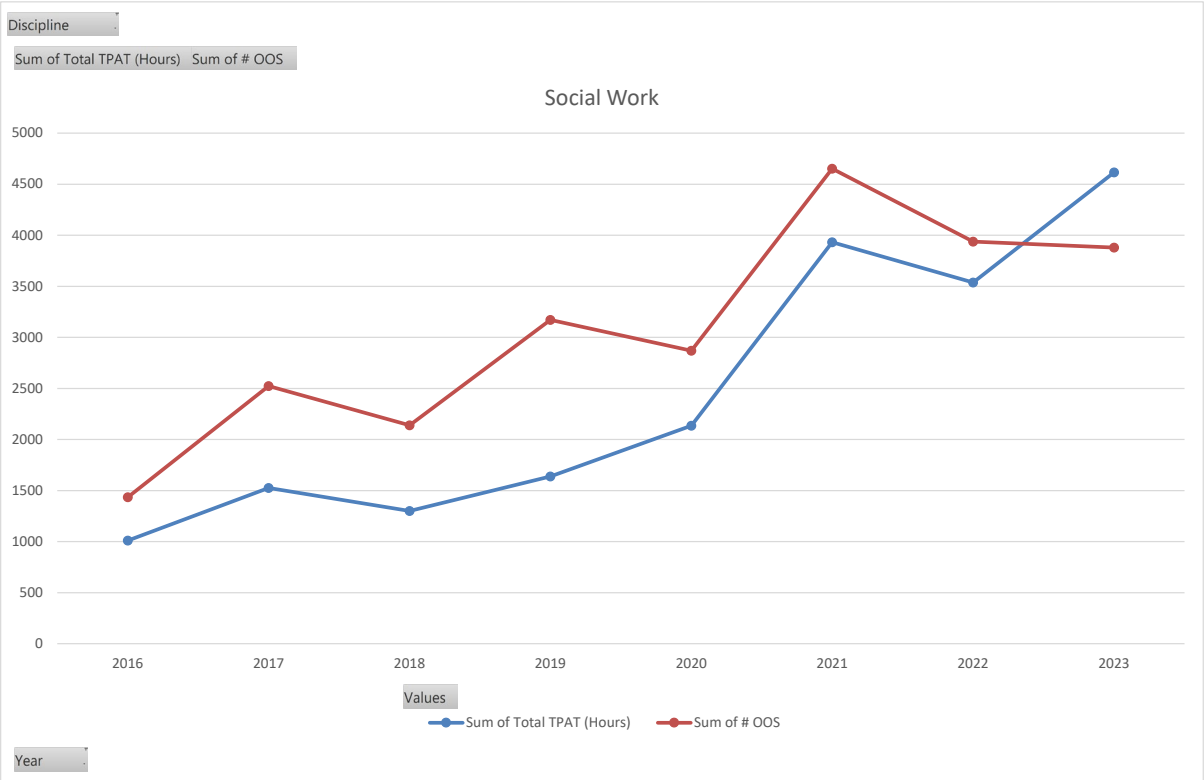
Note from Allied Health Manager: prior to November 2018, Ip rehabilitation podiatry service was provided by the MVH acute care team. From November 2018 to February 2022 there was no funded IP podiatry service.

## Psychology



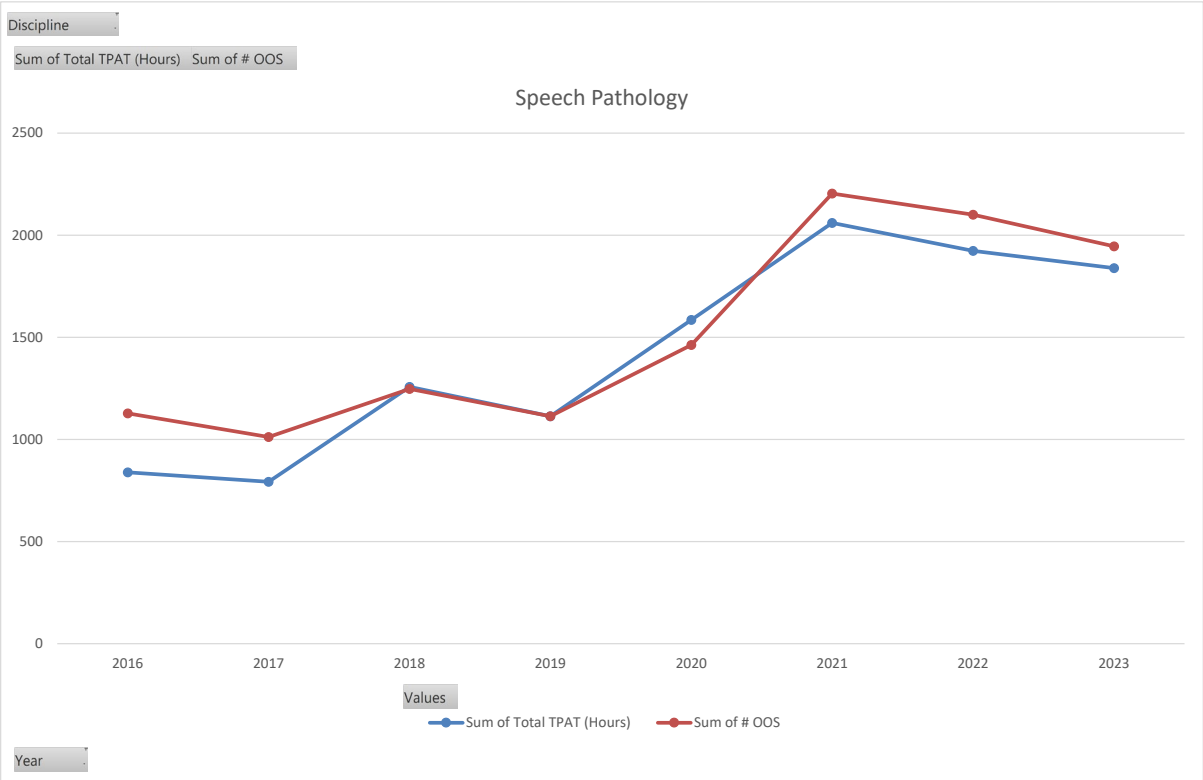

The activity data from 2016 to 2023 does not contain a noticeable trend, most likely due to the service disruption in 2020. The OOSs are similar in 2016 to 2023, with a decrease in TPAT seen in 2023 compared to 2023. It is notable that in 2021 and 2022 there was a significant increase in TPAT comparative to the other years.

## Social Work




There has been significant increase in both OOS and TPAT for social work activity between 2016 and 2023. Over this period OOS have more than doubled, with peak activity in 2021. There is notably an increase in TPAT to OOS ratio in 2023 suggesting that each OOS is taking more clinician time.

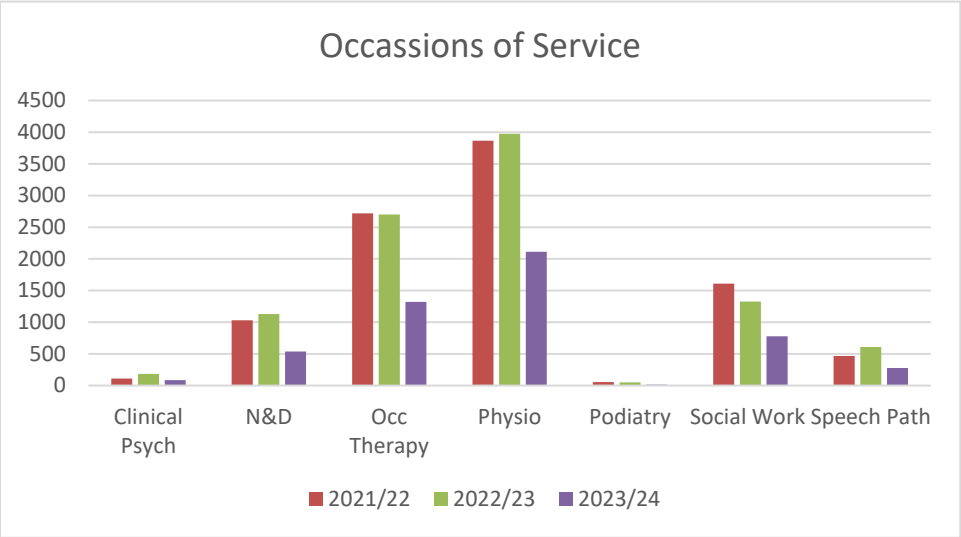
## Speech Pathology




There has been an increase in both OOS and TPAT from 2016 to 2023. Most of this increase occurred between 2016 to 2021 and there has been a slight decline in both metrics from 2021 to 2023.

## Appendix 8: Statistics – Breakdown of individual AH Disciplines for Palliative Care and GEM Units

The Palliative Care and GEM units opened in February 2022. Data for the FY 2012/22 has been excluded. Noting data for 2023/24 is only 6 months.

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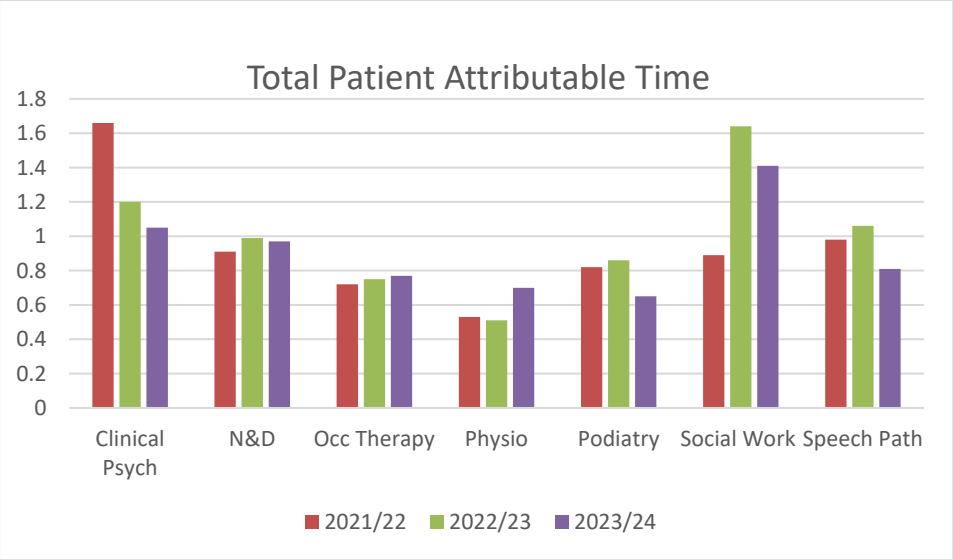


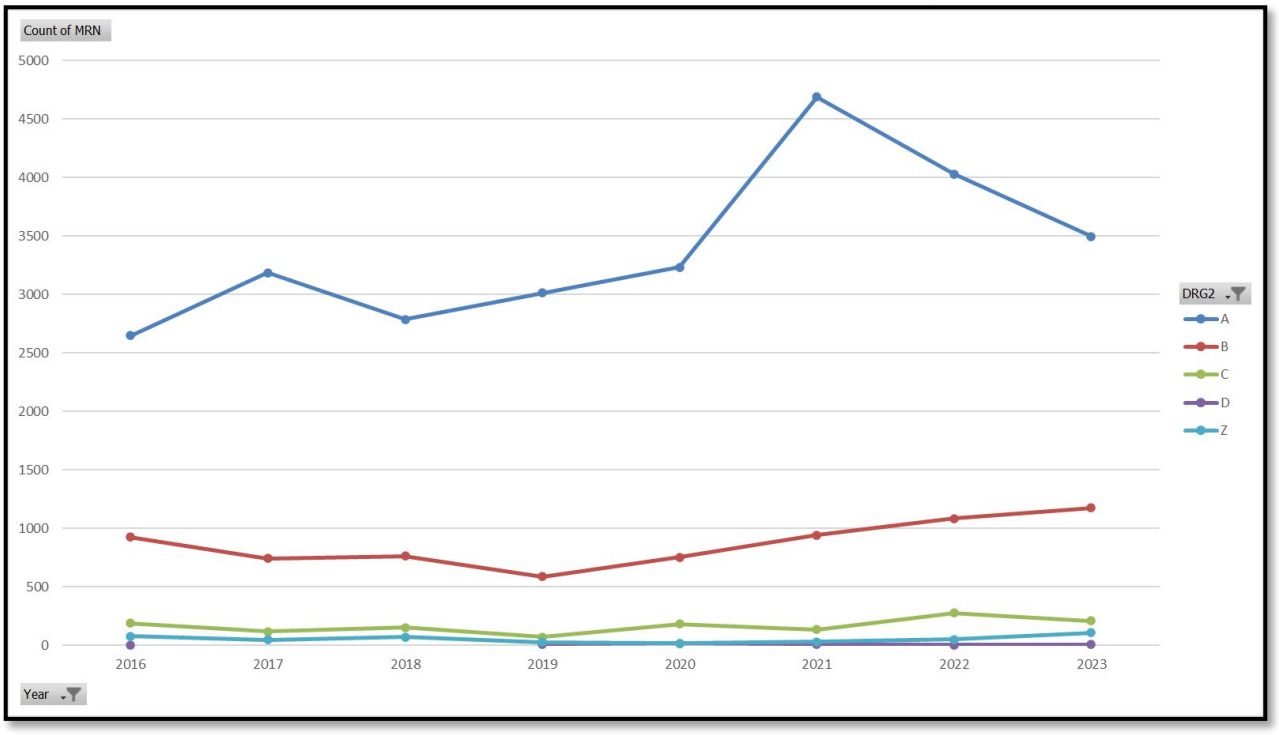
## Appendix 9: Changing Complexity of Patients for Inpatient Rehabilitation

This data has been provided by the NSLHD AH Data analyst. See Appendix 6 for full analysis. Diagnosis Related Groups (DRGs) are allocated to patients to indicate a patient's clinical category and level of hospital resource consumption. There are 5 splits at the end of a DRG into the categorisation:

- A – highest consumption of resources within adjacent DRG
- B – second highest consumption of resources
- C – third highest consumption of resources
- D – forth highest consumption of resources
- Z – no split for the adjacent DRG

Source: NLSHD Intranet, Diagnosis Related Groups (DRGs) classification system 2023 accessed by: http://intranet.nslhd.health.nsw.gov.au/ClinicalNet/his/coding/Pages/DRG.aspx

For the purpose of analysis, it has been inferred that patients with a DRG "A" and "B" will be more complex than the other DRGs however it must be noted that DRGs do not explain the whole picture in terms of complexity and subsequent additional AH resources required.

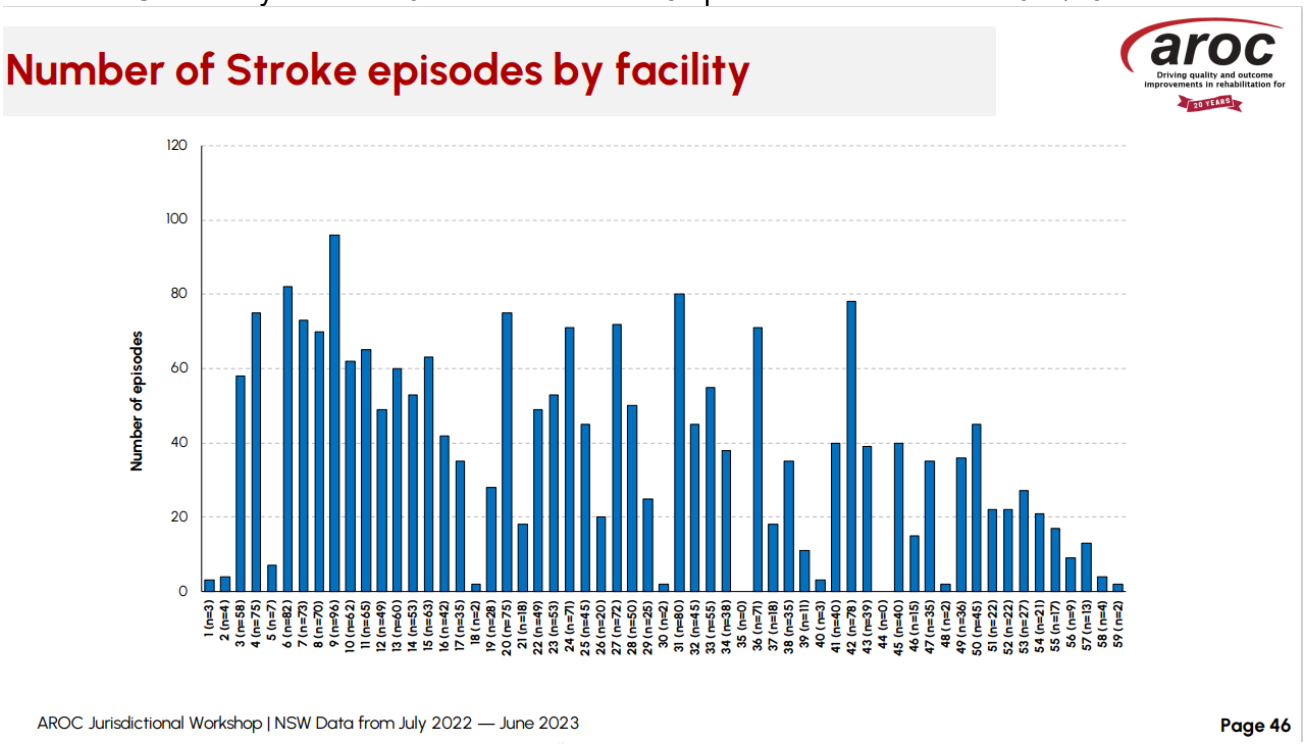



From 2020 to 2023 there has been an increase in the number of category A and B patient's seen by Mona Vale Allied health. For category A there was an increase of 8.1%, equating to 263 more patients. For category B there was a significant increase of 56.0%, equating to 421 patients more. However, when contextualising the data to each year's respective ratios (how many Category A/B/C/D/Z were in the whole year's context) there was a decrease in the proportion of category A patients and an increase in category B.

It is anecdotally reported that since BRU, opened there has been a rise in the number of stroke patients admitted and fewer orthopaedic rehabilitation patients. This is largely due to opening of

private rehabilitation facilities on the Northern Beaches that primarily admit more straightforward orthopaedic rehabilitation.
Data form the Australasian rehabilitation outcomes centre (AROC) has shown that MVH is one of the busiest stroke rehab units in NSW (see table? Below) and the busiest in NSLHD. These patients take up significantly more AH time compared to orthopaedic patients especially for disciplines such as SP, N&D and SW. In addition, prior to the opening of Arcadia Private Hospital in 2018, MVH would have admitted more orthopaedic rehabilitation patients requiring little to no input by these disciplines.

Table: BRU is facility number 20 in this table with 75 episodes of care for FY 2022/23



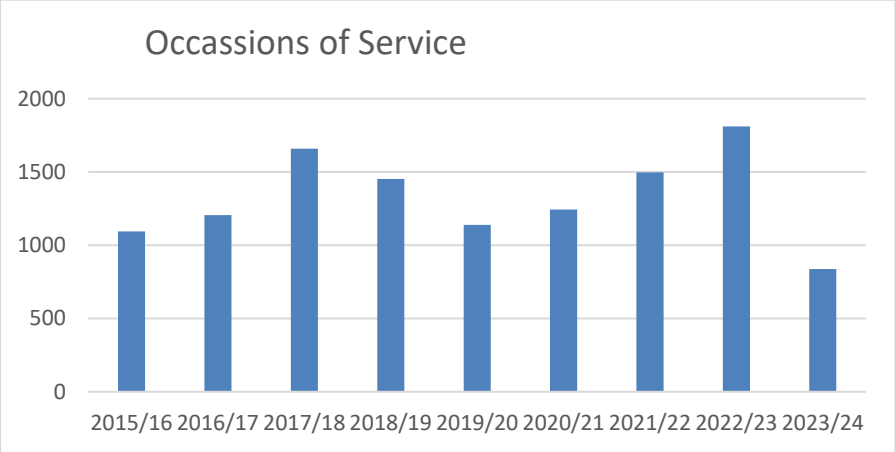

The following table shoes the most common DRGs seen at MVH in the last 3 years highlighting that strokes have been the most common.

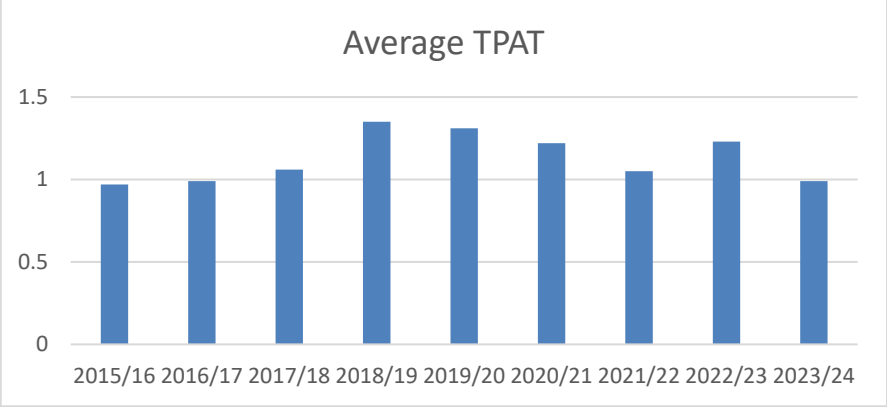
| Most common DRG (rank) | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|
| **1** | Stroke and other cerebrovascular disorders (A, 3596) | Stroke and other cerebrovascular disorders (A, 4869) | Stroke and other cerebrovascular disorders (A, 3025) | Stroke and other cerebrovascular disorders (B, 2336) |
| **2** | Stroke and other cerebrovascular disorders (B, 2285) | Fractures of neck of Femur (A, 2263) | Specific Musculotendinous Disorders (A, 2604) | Specific Musculotendinous Disorders (A, 1968) |
| **3** | Fractures of neck of Femur (A, 1982) | Other factors influencing health status (A, 2195) | Other factors influencing health status (A, 2440) | Stroke and other cerebrovascular disorders (A, 1683) |

## Appendix 10: Overview of FTE for Outpatient and Community Services and Statistics

## Statistics – Breakdown of Individual Disciplines for Outpatients and Community

**Nutrition and Dietetics:**

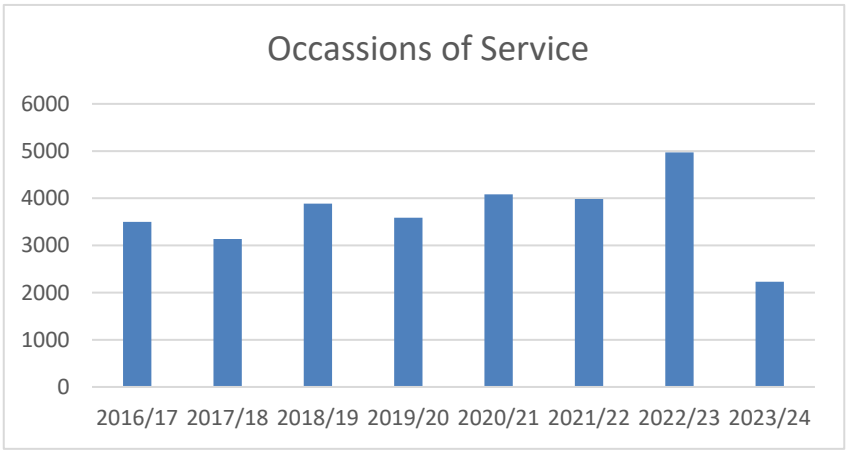


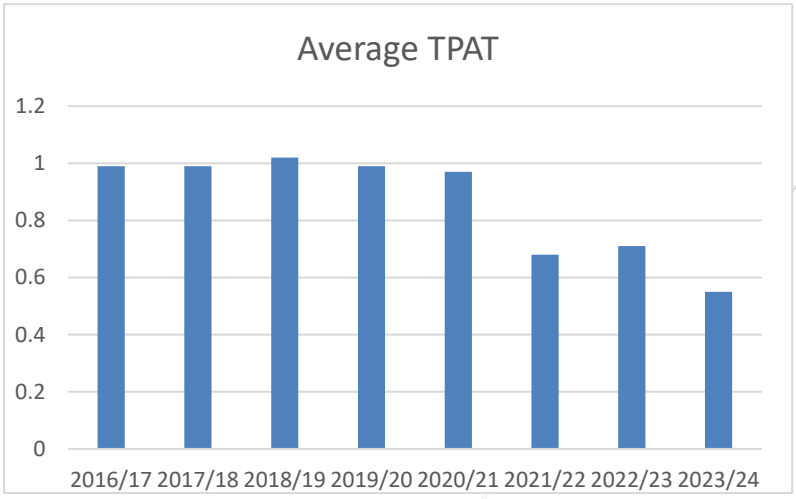




**Comments:**

- There was an increase in activity post NBH, followed by a reduction during CoVid. Last FY and potentially this FY, show significant increases in activity.
- Generally TPAT is higher since 2018 possibly supporting the increase in complexity of referrals post NBH, although TPAT for this FY is comparable to pre NBH.

**Occupational Therapy:** Data for 2015/16 not reliable

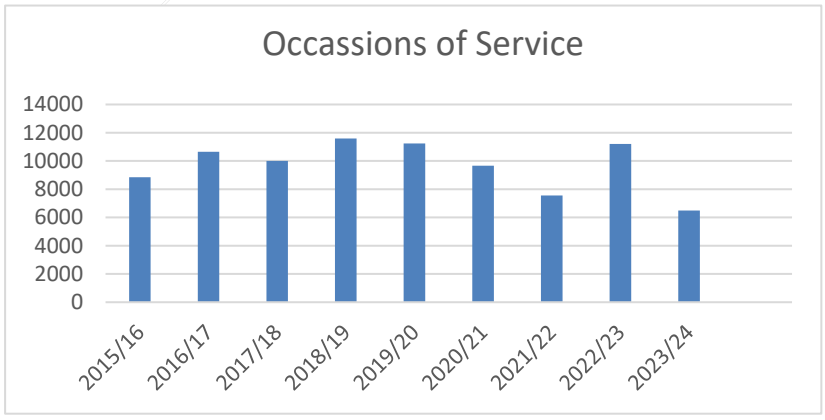


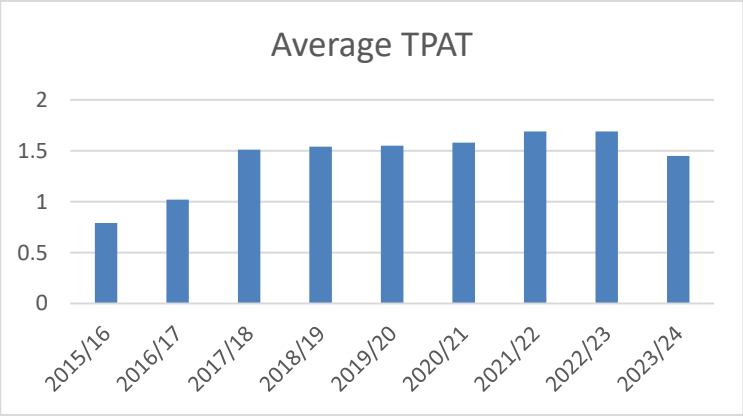




**Comments:**

- Activity did not dip during CoVid due to the need for ongoing service provision.
- Despite significant staff shortages from 2022, OOS have continued to grow due to a high volume of referrals
- and it can be assumed that this is reflected in the reduced TPAT.

**Physiotherapy:**

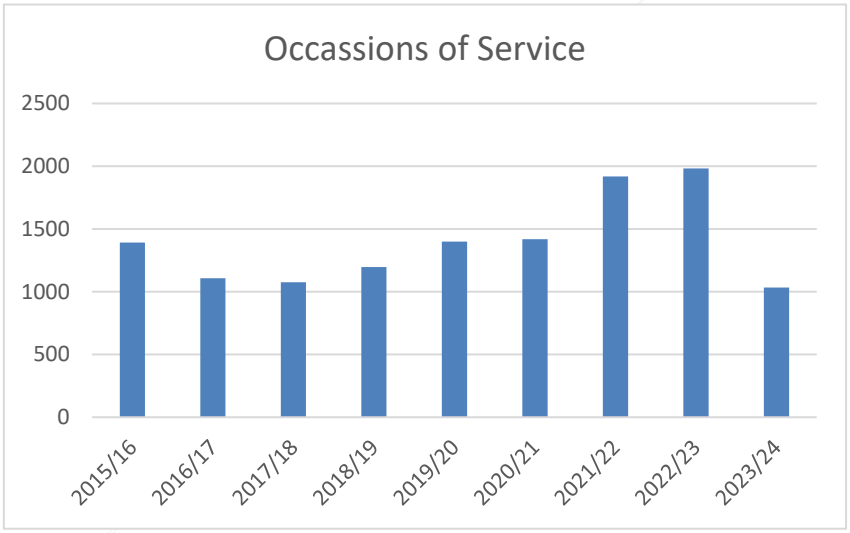


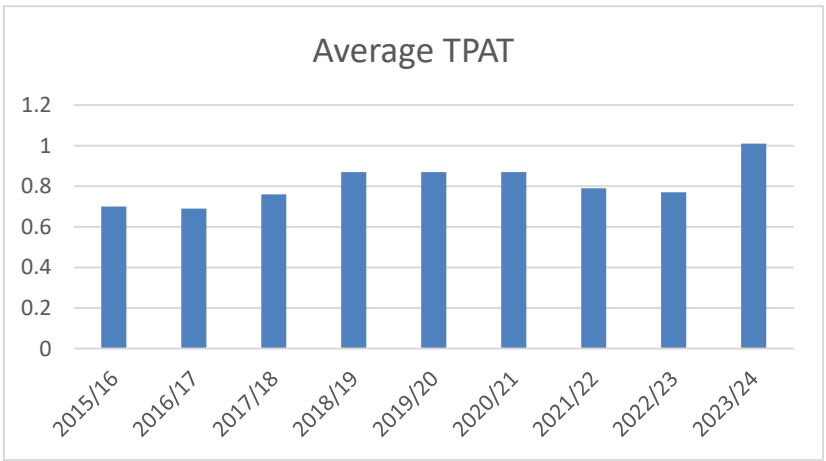



**Comments:**

- FY 2018/19 –transition of 1 FTE to the NBH. Since 2020, it is understood that this position no longer provides outpatient services and the patients are referred to MVH.
- Despite the transition of this position, activity is higher post CoVid than before the NBH opened.
- The increase in TPAT could be due to increased complexity of patients but this is unable to be validated.

**Podiatry:**

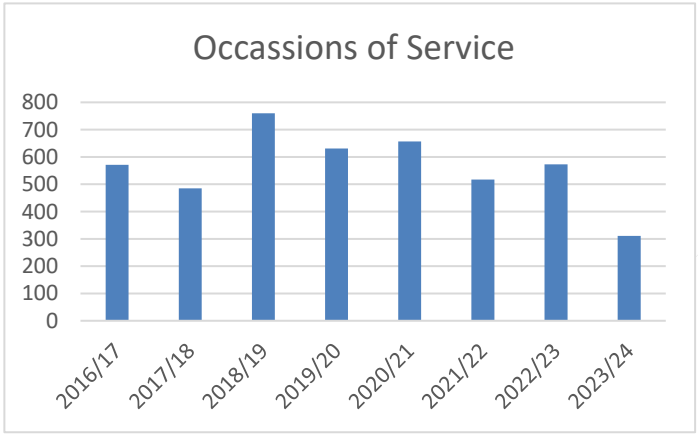


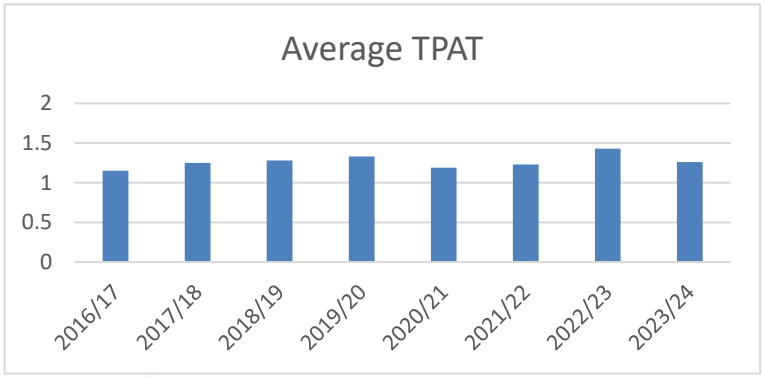



**Comments:**

- There has been a steady increase in activity since 2015 even during CoVid when the service continued to operate.
- The increasing number of urgent referrals to the service is requiring follow-ups to be pushed back.
- Overall TPAT has increased and this is anecdotally reported as due to increasing complexity and needs of the high risk foot patients.

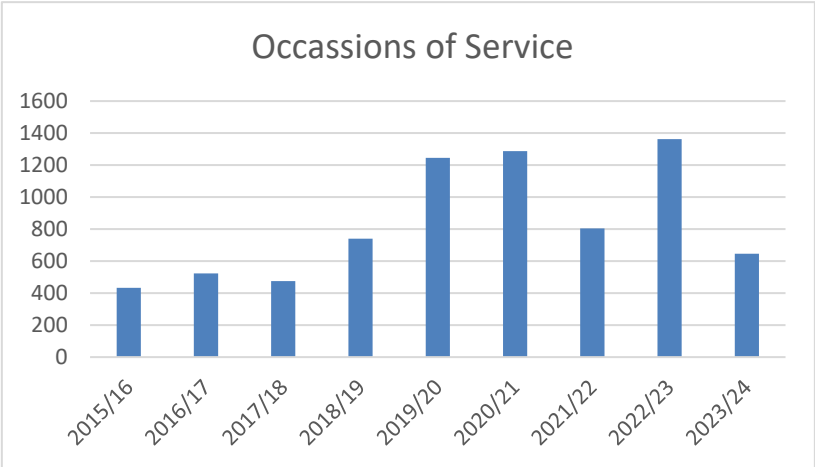
**Social Work:**

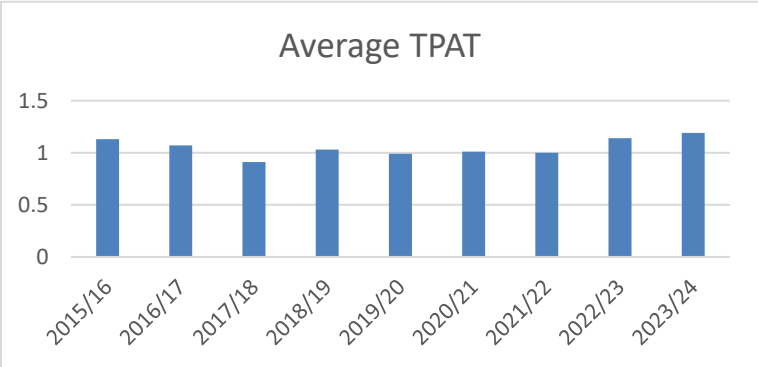



**Comments:** There has been fluctuating activity and TPAT has stayed approximately the same over time. OOS for this FY appear to be trending to previous levels.

**Speech Pathology:**




**Comments:**

- Activity has increased over time, with a dip during CoVid. This FY appears to be following the trend.
- TPAT has remained fairly consistent.

## Appendix 11: AH WH&S Control Measures

With respect to the further suggested controls, NSLHD proposes the following controls are implemented until 30 January 2024, when they will be opened for further review:

- **Patient Journey Board**: NSLHD considers the Patient Journey Board meeting is an integral part of clinical care. Allied Health staff should continue to attend the PJB meeting, however this meeting will be restricted to 15 minutes. Clinical Psychology and Neuropsychology may elect to not attend this meeting.
Update 15/1/ 24 - The HSU has sought feedback from members and endorsed to agree to: individual clinicians will decide whether to attend the PJB based on their capacity and the safety of their workload, as well as considerations of the importance of the particular PJB.
- **Case Conference**: NSLHD suggests Allied Health staff may not attend the Patient Journey Board Meeting on the day of the case conference, and suggests Physio, OT and Social Work should attend the Case Conference. Dietetics, Clinical Psychology, Neuropsychology and Speech Pathology may not attend the case conference during this period, and otherwise provide a clinical handover for the meeting.
- **Quality Improvement (QI) Initiatives**: NSLHD considers that QI is an essential component of clinical care, although acknowledges some QI may need to be delayed through periods of reduced staffing. NSLHD accepts allied health may not participate in all QI activities through this period.
- **Documentation Audits**: Consideration of Allied Health staff withdrawing from in-patient Documentation Audits will be considered as the requirement to undertake the audit arises. While it is appreciated that this is an administrative burden, there are also key reporting requirements as a result of these audits. Importantly, the outpatients/ community documentation audit must be continue to be completed, to ensure compliance with Commonwealth Home Support Program (CHSP) funding requirements.
- **NSLHD Allied Health Data requests:** Any requests for Allied Health data should be provided to the Allied Health Manager, who can assess and respond to the request accordingly.
- **Monthly Allied Health statistics:** Frequency of monthly stats will be reduced to quarterly during this period. Additional requests for stats will come through the Allied Health Manager for consideration/ discussion with relevant Heads of Department.
- **Allied Health Representation in MVH Site Committees:** An individual assessment of each of these committees should be undertaken, noting the role these committees have in ensuring ongoing patient quality and safety, and the contribution of these committees to meeting Accreditation requirements. In individual circumstances, if the Terms of Reference for the committee can be met through the use of appropriate Allied Health representatives, this will be reviewed and accepted.
- **Hand Hygiene Audits:** Hand Hygiene audits directly support patient care, and so continuation of these audits is required. If appropriate audits are able to be completed by Allied Health Assistants, this is acceptable to MVH.
- **Home Visits:** NSLHD agrees that home visits should only be conducted following an assessment of clinical need, and not as a blanket referral.
- **Young Adult Clinic (YAC) for diabetes:** MVH will urgently review the need to provide ongoing service to the YAC for diabetes and liaise directly with Nutrition and Dietetics staff regarding this service.

In addition to these controls, NSLHD notes that:
- The recently developed Fatigue Management process (using NSW Health tools) will be piloted in Physio.
- Clinical Prioritisation documents will remain in place to manage reasonable workload.
- “Missed Breaks” logs will remain in place to monitor instances of workload impacts on meal breaks.
- Time in Lieu/ Overtime process to remain in place. Recruitment to all department casual pools continues to be supported.