PSA

Submission on the Draft Southern Strategic Health Services Plan 2015 – 2025

21 November 2014

For a better working life
New Zealand Public Service Association
Te Pūkenga Here Tikanga Mahi

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Introduction

Who we are

The New Zealand Public Service Association Te Pūkenga Here Tikanga Mahi (the PSA) is the largest trade union in New Zealand with over 58,000 members. We are a democratic organisation representing members in the public service, the wider state sector (the district health boards, crown research institutes and other crown entities, state owned enterprises), local government, tertiary education institutions and non-governmental organisations working in the health, social services and community sectors.

We have around 17,000 members nationally in the district health boards, mostly employed in clerical, administration, nursing, allied health and support staff roles. In the Southern District Health Board 974 staff are PSA members, many of whom may be affected by any service changes resulting from the implementation of this plan. Additionally, we have over 400 members employed in private and not for profit providers contracted to the DHB who deliver disability and home support services to Southland residents. Their jobs may affected by some of the proposals in this plan for new funding arrangements and new models of care.

Through the New Zealand Council of Trade Unions Te Kauae Kaimahi, we work closely with other health sector unions on matters that affect our members and the services they provide to New Zealanders.

PSA submission

Summary of PSA views and recommendations

PSA members have questions about the impact on jobs

PSA members working in the Southern District Health Board and in health and disability care providers contracted to the DHB support the focus on longer term planning, and the six priorities in the draft Southern Strategic Health Services Plan 2015 – 2025 (SSHSP). They do, however, have substantial questions about the vagueness, lack of transparency and lack of detail in the plan and in particular these questions centre on the likely impact on jobs and on the quality of services.

Consultation has been poor

Members feel that consultation with staff to date has been poor; we expect that this will be rectified in the next stages.

There are four broad areas of concern:

1 The focus on '*containing personnel costs … through both the numbers of staff*

Reducing staff numbers and relative costs is about contracting out services to third sector providers

and their relative costs' signals the intention is to reduce both staff numbers and wages costs. Members are concerned about maintaining service levels and quality, particularly in interdisciplinary care, with fewer staff. Containing 'relative costs' of staff is about shifting provision to lower-qualified, cheaper staff in contracted providers and / or seeking lower wages and conditions for experienced clinicians.

Contracting out leads to lesser terms and conditions

2 Shifting services closer to the community: While there may be valid reasons for new models of care, there are significant workforce implications. Our experience is that the DHB contracting model leads to the erosion of terms and conditions over time, as services are squeezed by funding pressures, leading to lower quality jobs and lower quality services. DHBs have a statutory obligation to be good employers and they should not abdicate the responsibility.

3 Shifting from specialist models to generalist models and regional responsibility for specialist care: Members fear that Otago/Southland will lose out with tertiary services being provided out of Canterbury. The consequent impacts on Otago University's role in teaching and training the national health workforce must be factored in.

Little focus on allied health, or on clerical & administrative roles

4 Minimal recognition of allied health and technical roles, and of administrative and clerical roles: The SSHSP does not appear to fully acknowledge the role of allied health in moves towards holistic new models of care. Nor does it mention the role of the administrative and clerical workforce in running efficient systems that save costs.

PSA proposes good employment relations practice in any change

Even though the SSHSP is labelled a draft, there is a detailed implementation plan. PSA members expect to be fully engaged and consulted in the next stages, and that there will opportunities to modify and improve the SSHSP as it progresses. If there are any changes to jobs and service models, the PSA expects that good employment relations practice will be followed and we suggest some elements for this.

High engagement / high performance work practices support productivity

The PSA is committed to transforming members' workplaces through high engagement / high performance work practices, which bring significant productivity benefits and cost savings. We would be happy to discuss how PSA can work with SDHB on productivity improvements.

General comments on the proposal

Our members welcome the opportunity to put forward their thoughts on the draft Southern Strategic Health Services Plan 2015 – 2025 (SSHSP). In principle, they endorse the focus on longer-term planning and the six strategic priorities:

- Develop a coherent Southern system of care
- Build the system on a foundation of primary and community care
- Secure access to sustainable specialist services
- Strengthen clinical leadership, engagement and quality
- Optimise system capacity and capability

- Live within our means

Members have reservations about the proposals because of the lack of information about the impacts on jobs

It is hard to disagree with such a high level set of goals, but the overall sense of the plan is one of vagueness, lack of transparency and lack of detail – there is much about 'new operational models', 'new models of care' and so on, but no tangible sense of what these will look like, how they will be achieved and what they will mean for the staff of the DHB. Do they mean further contracting of services to the third sector? If so, what services will be affected and how will the service be improved in the new model? Do they mean more user pays charges; do they mean more use of private sector facilities? Members want to see what the proposed health model and delivery system will look like. Without such information, PSA members at SDHB have considerable reservations about the proposals and the likely impact of their jobs and the services they deliver. The Priority 6 focus on constraining staff numbers and costs intensifies this concern.

They want to be assured that the proposals are not just about cheaper, lower-quality services

PSA members recognise that the health care system must adapt to population, technological and other drivers of change and that it must be responsive to community needs. Given rising demand and citizens' increased expectations of good health care outcomes, there is considerable pressure on health workers (and their managers) to deliver sustainable, high-quality services within constrained funding for the foreseeable future. The message from central government is that there is only limited, and highly targeted, new funding available[1]. This is an important context for the SSHSP, and is the lens through which much of the plan needs to be seen. For example, the plan talks about shifting resources to provide services closer to patients in the community; there may be some benefits in this, but members will want to be assured that it is not just about providing lower-quality services more cheaply and reducing both staffing numbers and wages costs. But the statement on p17 of the summary document about *'containing personnel cost growth in the SDHB Provider Arm, through both the numbers of staff and their relative cost'* seems to us to make it clear that this is in fact the intention.

Funding will be needed for implementation

Members note that when mental health went through the major changes in the early 1990s (the Mason Report and the Blueprint), it required a significant funding injection, and that some changes still have not been achieved. They note that additional resources had to be allocated to mental health during this period – for example, psychology FTEs in Southland went from 2 to around 15. Trying to make the major changes that the SSHSP envisages will need additional resourcing to succeed.

PSA has extensive experience in

As key stakeholders members expect to engage, through their union, in the development of the finalised plan, and in its implementation. The PSA has arguably the longest and broadest experience of change management and restructurings (both large and small, and across all sectors of our membership) of any organisation in the country, and our strong view is that the full and early

[1] See the Ministry of Health's briefing to the incoming Minister of Health, 12 November 2014. http://www.health.govt.nz/publication/briefing-incoming-minister-health-2014

change management processes

engagement of all staff and good, robust change management practice is key to successful implementation.

High engagement / high performance work practices deliver productivity benefits

In Priority 6 '*Live within our means*', there is a focus on the need for improved productivity and service performance and quality improvement; we agree that this is desirable and necessary in a constrained funding environment. The PSA would like to see a commitment by SDHB to working with staff and their unions on high engagement / high performance work practices and the workplace culture that supports them. There is a significant body of evidence that workplaces where staff feel valued, their ideas are supported, and where they have a voice that is listened to by management are more productive, leading to the financial benefits that flow from higher productivity. We are working with several DHBs on successful productivity programmes based on these principles, and would be happy to provide more information on this. Our strong view, and our experience, is that there are considerable – and financially quantifiable – benefits in such work practices, and we would like to discuss how PSA can work with SDHB in putting them in place.

PSA member concerns with the plan fall into four broad areas, which are set out below.

*1 'Containing personnel cost growth in the SDHB Provider Arm, both through **the numbers of staff and their relative cost**'* (our emphasis).

Allied health members are concerned that benefits of interdisciplinary care may be lost

As we note above, PSA members are concerned about the focus on both reducing numbers and reducing their relative costs. Much more detail is needed on this, as early as possible. The first part of this – reduced staff numbers – implies that there will be fewer staff doing the work. Given that one of the strategic priorities (no 4) is to '*Strengthen clinical leadership, engagement and quality*', we question how this can be achieved with fewer staff. Our allied health members in particular fear that the benefits of interdisciplinary care, health prevention interventions, and optimising independence and the quality of life will be diminished or lost. Interdisciplinary care is vital – allied health professionals need to be working alongside medical, surgical and nursing staff to achieve best outcomes for patients. How this can be attained with fewer, cheaper staff must be questioned. They make the further point that contracting-out and private provision of allied health services will create costly and unnecessary boundaries between the public and private systems, impacting on the sustainability of quality health care services.

Our physiotherapist members have commented that the length of the physiotherapist outpatient waiting list would tend to suggest understaffing, rather than the need to reduce numbers.

If jobs are contracted out, the union must be fully engaged. Terms and

On the face of it, we interpret the second part of this as meaning that the intention is to shift provision out to lower-qualified, cheaper staff in contracted providers. If this is the case, then staff and their unions must be fully informed about the intention and about the impact on current jobs. While we do not disagree with

conditions must be maintained.

providing services close to users and their communities, we have real concerns about sustaining an appropriately qualified and resourced workforce, maintain the links to the DHB and its services, ensure that it is adequately professionally supervised and that terms and conditions of employment are maintained.

2 Providing services closer to the patient in the community

Changing population needs and moves towards supporting people who need care to remain in their communities are driving shifts to new models of care and different ways of working. In principle, PSA supports this, but there are significant workforce implications that must be worked through.

The plan talks about the need for a 'Southern system of care', with eight localities across the region providing the planning and coordination of local services across provider entities. Otago/Southland is a large region and we support the need for a Southern-specific system to be developed. The size of the region makes service delivery challenging, and limits the scope for economies of scale and service, so these factors must be taken into account. And the potential for further costs in administration, duplication of services, the need to monitor service quality and public subsidy of private providers through the use of public health facilities are all matters that must be fully factored into the eventual business case.

The reason for shifting services to the third sector must be for better patient outcomes, not cheaper costs

The PSA has a large number of members who work in the third sector as disability and home care support workers, so we have a good understanding of how that part of the health sector works, and what its opportunities and challenges are. The services are valuable, and valued, supporting people to stay safely in their homes and to lessen the cost burden on acute and secondary provision. We would be extremely concerned if shifts to new models of community-based care were seen as a way to deliver care more cheaply. We have members doing similar jobs in both DHBs and the third sector (for example, social workers, mental health nurses, care assistants) and we see that wages and conditions are considerably lower in the NGOs. The primary reason for any shift to community services must be better clinical outcomes and more autonomy and control over the service for the person receiving the care. Cost should not be a factor in the decision, and any savings should be reinvested in the service.

As good employers, DHBs must ensure that terms and conditions are protected in

Jobs in community-based care services are generally low-paid, mainly at the minimum wage level or slightly above. It is instructive to apply a gender analysis in looking at the wages and conditions for these jobs, which are mainly done by women. The Employment Court found[2] in the recent Equal Pay Act case that the pay of residential aged care worker Kristine Bartlett is so low because she works in a female-dominated industry, where the work is undervalued compared to work done by men. We do not yet know what the final outcome of this decision will mean for the sector. Workloads for these women's jobs are high, and the

[2] http://www.justice.govt.nz/courts/employment-court/documents/2013-judgments/2013-nzempc-51-service-and-food-workers-union-nga-ringa-tota-inc-v-terranova-homes-and-care-ltd/view

contracted out services

contracting model means that service improvements are sought within existing funding levels, leading to considerable stress on services and workers, who are dedicated to their clients and their needs. When services are moved out of DHBs, who have the statutory good employer obligations and collective employment agreements in place, to third sector providers, our members' experience is that terms and conditions are eroded over time, leading to lower quality jobs. It is hard to maintain service quality levels in this environment.

The PSA will expect assurance that moves towards shifting services to the third sector are carefully thought through, adequately funded and monitored, and that workers' terms and conditions are fully protected.

3 Shifting from specialist models to generalist models, and having regional responsibility for specialist care.

Tertiary services must be retained in Otago/Southland

We are particularly concerned at the move towards regional specialist care, with the region being the entire South Island. Our fear is that Otago/Southland could become a secondary facility, with tertiary services being provided out of Canterbury. Members are clear that immediate transfer to a tertiary hospital – within 60 minutes – must be retained; and Dunedin must retain cardio-thoracic surgery.

A further concern is that the important role of Otago University in teaching and training medicine, nursing, allied health and other health disciplines should not be undermined in a shift to generalist models and regional responsibility. These courses are nationally important to the whole of the health system, and must be internationally credible and recognised. They support the regional economy. We expect that the final plan will have addressed this matter and that the role of the university in shaping and supporting the local and national health workforce will be maintained.

4 Minimal reference to the role of allied health and technical roles, or to clerical & administrative roles

Allied health and technical roles, and administrative and clerical roles, must see their work reflected in the plan.

We find it surprising and alarming that the plan makes minimal reference to allied health and technical roles, but does look extensively at medical and nursing roles. While medical and nursing services are of course vital to the health system, they are part of a wider workforce. Part of the rationale for moving to new models of care and new ways of working is the need to take an all-round, holistic view of the health system and workforce roles, which we support. It is surprising – and worrying – to find that the plan does not appear to have fully acknowledged the function of allied, technical and scientific roles in supporting optimal health care in the community.

Many of the health targets are connected to health behaviour change and programmes and services delivered by allied health and public health workers. Treatment adherence and treatment engagement are the key factors, and how this

work is addressed and supported is crucial.

We would also note the importance of the clerical and administrative workforce in ensuring that clinicians are able to focus on clinical work, and that systems run smoothly and efficiently. For example, the role of clerical and administrative staff in reducing the numbers of 'do not attends' at clinics and appointments is key to making savings and efficiencies in this area.

This is a matter that we expect to see addressed in the final plan, and we expect to have further discussions on this as part of the next stages of consultation before the plan is finalized. You will appreciate that it is worrying and demoralising for our members not to see their work reflected, but obscured in the vague language about shifting to new service delivery models. They need assurance that their work is respected, will be retained and that they will be fully supported to deliver even better care in the future.

PSA engagement in the next stages of consultation

Consultation to date has been poor; PSA expects better practice in the next stages

We note that, even though the plan is in draft, a detailed implementation plan beginning in the third quarter of 2014 is set out on pp 90 – 91. We hope that it is not set in stone and that it will be modified according to the outcome of this consultation. Our members have said that the efforts to date to engage and consult with staff have been poor – for example, there was only two days' notice for the consultation meeting at Dunedin Hospital and no initial meeting set at Waikari. The next stages of consultation with staff must be a significant improvement on this.

In particular, the PSA wants to be assured that any changes to service models and configuration will be achieved by best practice in any change management arrangements. Good employment relations practice will include:

PSA wants to see best practice employment relations in any change processes

- Commitment to minimising job losses, through reassignment and redeployment mechanisms and no involuntary redundancies
- Maintaining terms and conditions, with no overall reduction in working conditions
- Fair redundancy provisions and entitlements where there are job losses, and support for job search
- Fair procedures for staff whose jobs are transferred to another organisation or contracted out
- Support for training to acquire skills, either for a job within the DHB or outside its employment
- Maximise support to staff throughout the transition process and treat staff fairly and with respect
- Maximise staff involvement in the changes, and full and open engagement with unions

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