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Leading the Recruitment Industry

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16 May 2002

Mr Tim Grimwade
General Manager
Adjudication Branch
Australian Competition & Consumer Commission
PO Box 1199
Dickson ACT 2602

Dear Mr Grimwade

**Health Purchasing Victoria Application for Authorisation Nos A90811 & A90812**

Please find enclosed a further Submission relating to the above amended Application for Authorisation prepared by the Recruitment and Consulting Services Association Ltd (RCSA) on behalf of members of both the RCSA and the Nursing Agencies Group.

The RCSA submission opposes the granting of the amended Application for Authorisation by Health Purchasing Victoria.

If so requested, the RCSA is prepared to make oral representations on the matters outlined in the submission. Additionally, should you require any further information, please do not hesitate to contact the Association.

Yours sincerely

**George Zammit**
President
RCSA Vic/Tas Region

## EXECUTIVE SUMMARY

Thank you for providing us with the opportunity to present additional comments against the revised HPV tender.

As outlined within the Commissions' covering letter and within the tender, the HPV tender now incorporates the Department of Health Services Directive ("Directive"), stating that

1. a temporary nurse supplied by the tenderer to perform nursing services that would otherwise be performed by a permanently employed nurse must be engaged and paid at the same grade as the permanently employed nurse.

2. the maximum price payable to the tendered for the supply of a temporary nurse must not exceed;
   - 80% above the basic Award/EBA rate for the replacement grade nurse; plus
   - 15% above the allowance provision included in the Award/EBA for the replacement grade nurse.

(The Directive additionally requires that hospitals only utilise agency nurses to fill unplanned or emergency absences.)

The RCSA has reviewed the amended document submitted by Health Purchasing Victoria (HPV) .

The RCSA continues our objections to the previous tender and in addition, believes that the inclusion of these modifications further increases the anti-competitive nature of the tender and most importantly, can be demonstrated to promote diminished public benefit within the Health Care System. We believe that the implementation of the DHS directive and the tender process is harmful to the general public, harmful to nurses, and has not and will not produce the alleged savings cited by hospital administrators as a public benefit.

In addition to the requirement to pay nurses at award rates of pay, the amended tender also requires that agencies who wish to participate within the tender process, provide pricing within a capped range of 80% of the base award rate for a nurse. By capping the maximum price that can be charged to hospital, the tender has become even less competitive than the previous version and may effectively reduce the number of companies that could participate within the tender process, should they elect to do so.

As noted by the Commission, the introduction of the Directive has in part pre-empted a number of anti-competitive impacts that would have stemmed from the introduction of the tender. Additionally, by forcing participating agencies to pay nurses at the award rate of pay, the RCSA is already seeing the negative effects predicted in our original submission.

The Directive was introduced under Section 42 of the Health Services Act 1988. While it may be legal for Health Services Victoria to make such a Directive, if the ACCC was to grant authorisation to the tender it would be implicitly supporting a proposal which is contrary to both public benefit and promotes anti-competitive behaviour within the Victorian Health Care system.

It should be noted that not all agencies have agreed to operate under the Directive and that we believe that not all hospitals are working strictly within the confines of the Directive.

## ADDITIONAL ANTI-COMPETITIVE ISSUES

Section 3.3 of Part B of the HPV tender previously stipulated that agencies were to remunerate nurses at or close to the award. In addition, agencies were to provide a pricing structure outlining any above award payments, the applicable service fee, (defined as either a flat fee or as a flat fee with a variable component) and any discount mechanisms.

As submitted by the RCSA, we believed that the requirement to pay nurses at or close to the award would have significant, detrimental effect to nurse availability and a subsequent 'knock on' effect on the health system.

The proposed amendment moves the focus from the amount paid to the nurse to the maximum capped rate that can be charged to the hospital, however, this has an obvious impact on the amount that can be paid to a nurse.

In accordance with the Nurses (Victorian Health Care Sector) Award, all casual nurses must be paid 25% above the base award level. To meet the 80% capping rule, an agency can at most apply a 44% mark up to the casual award rate that it pays the nurse. As outlined in the RCSAs' previous submission, the *average* agency mark up is around 44%. Therefore, the modifications to this tender still implicitly require the agency to pay nurses at or close to the award rate of pay.

The proposed modifications to the tender cap the amount that can be charged to the hospital, but ignore the fact that many agencies may not be able to provide staff at this rate. Given the nature of an open tender, most respondents would provide costing within the *average* mark up, however, each individual agency would need to assess any additional on-costs associated with doing business under such a tender.

Additional costs may apply to account and tender management, additional reporting requirements, additional risk allowances for non-performance, or most significantly, any additional public liability issues with regard to further indemnifying health services against staff liability. The services to be provided by nursing agencies are more onerous than those to be provided by nurse banks, therefore any potential increase in mark up above the average rate, would still offer very good value.

The tender process specifies 13 criteria for evaluation of the successful tenderer, with price representing only one component. It is not unreasonable to assume that while agencies may provide very competitive pricing, their pricing would also be structured to incorporate the cost of them providing any additional services to hospitals, in order for them to fully meet the evaluation criteria.

As such, variation in pricing and service provision will occur between each agency, which the HPV would need to assess as part of the overall agency evaluation. By capping the maximum price that can be charged to hospital, the tender has become even less competitive than the previous version and may effectively reduce the number of companies that could participate within the tender process, should they elect to do so.

It should be also noted that because an agency has been forced to comply with Directive, it does not necessarily mean that they would support or participate in any such tender process. Current agency operations should not be interpreted as an acceptance of the terms of the tender process, in any way.

## PUBLIC BENEFIT

The previous benefits identified by the HPV can be summarised as follows:

- Reduction in the overall nurse staff costs to health services
- Employment equity and workplace harmonisation
- Price certainty
- Reduction in the bargaining imbalance and promotion of equitable dealings
- Increase in nursing staff availability
- Fostering business efficacy

These benefits were to be largely achieved by the fallacious argument that forcing agencies to pay nurses at the award rate of pay would:

- reduce expenditure on agency nurses;
- cause nurses to join nurse banks; and
- increase the number of hours that nurses would work, as they would get paid less wages.

The RCSA and a number of its member agencies have previously provided statements to refute the stated public benefits, which we continue to support.

We do not see any additional public benefits that may arise as a result of the incorporation of the terms and conditions of the tender within the document.

However, we believe that there is an additional invidious aspect of the DHS directive and its' flow on to the tender. The grade for grade replacement requirement of the DHS directive and the tender proposal also means that in many cases we would be required by the government to pay the nurse at less than the award rate. As many hospitals are utilising large numbers of staff too junior for the roles (due to the shortage of experienced nurses at reduced pay rates) absenteeism is significantly increased and along with it, the need for experienced agency nurses.

However, any nurse who is asked to fill that role will only receive the lower rate of the junior nurses whose role is being filled. Senior and experienced agency staff with certificates who choose to fill public hospital shifts may well be paid at a level many years below their actual level and without the certificate allowance. We believe it is incorrect for the government to legislate for nurses to be paid less than the award rate.

## THE IMPACT OF THE TERMS AND CONDITIONS OF THE DIRECTIVE

Since the HPV tender was first submitted to the ACCC for authorisation, the Victorian State Government has initiated a number of different activities to promote nurses joining nurse banks or becoming permanent members of staff, in order to achieve what the HPV tender was proposed to do. The most notable of these initiatives are a $2M media campaign aimed at attracting nurses back to nursing and nurse banks, and the introduction of the Directive regarding the conditions of use of agency nurses, subsequently incorporated into the proposed tender.

The Victorian State Government has claimed that they have recruited over 1000 nurses to the nurse bank system since February 1, 2002. In addition, the Directive has been in place in some public hospitals from mid-March and all public hospitals since April 4th, 2002. Part of the Directive requires that hospitals utilise agency nurses only in emergency or unplanned absence. Therefore it would be our expectation that with the purported increased number of bank nurses and decreased requirement for agency nurses, that our member agencies would have observed a marked downturn in *demand* from public hospitals. This has not been the case.

While demand for agency nurses in most nursing sectors has largely returned to the pre-Directive amount, *the ability of nursing agencies to fill shifts* with nurses who are willing to work at the award rate has been severely diminished. Nurses are unwilling to work at the lesser rate through agency or nurse bank. Amongst the 15 member agencies, we have observed that there has been a 30% decrease in the ability of agencies to provide nurses who are willing to work at award rates of pay for public hospital shifts. This is not due to a net reduction in number of nurses, but to the nurses demonstrating their unwillingness to work under these conditions. This is clearly contrary to public interest. We do not believe that this situation would change with the introduction of a tender.

As such, the impact of the Directive and its' requirement to pay nurses at award, can be used to substantiate the issues which the RCSA originally raised to refute the alleged public benefits of the tender.

Over the last 8 weeks, RCSA member agencies have been in receipt of a significant amount of information pertaining to the impact of the Directive within the Victorian public health system. Although there is a significant lack of publicly available quantitative information regarding the issue[2], it has been observed that, due to lack of available agency nurses within the public health system, the following worrying trends are beginning to emerge:

- There is an increasing number of bed closures, bypasses and limitation of patient admission to certain postcodes by some hospitals due to lack of staff;
- There is an increasing use of overtime, or nurses being required to undertake double shifts, often unwillingly;
- There is an increasing length in waiting lists, with allegations that the waiting lists have blown out. The Victorian State Government has announced that it will spend an extra 6 million on reducing waiting lists and "getting more nurses";
- There is an increasing number of sick nurses being asked to continue to work;
- Due to lack of agency nurses, a number of public hospitals have resorted to the use of inappropriately skilled nurses and students instead of using skilled staff; and
- In some hospitals, last years graduates are supervising this years graduates as they are the most skilled members on the employed staff and when agency nurses do attend, they will often be significantly more senior and experienced and be required to mentor the junior nurses.

The impact of the Directive, or of the tender were it to be authorised, will be significantly detrimental to achieving any of the proposed benefits to the public. The tender will further restrict the availability of agency nurses and these worrying trends will be greatly exacerbated, to the detriment of patient care.

## 1. Reduction in the Overall Nurse Staff Costs to Health Services.

As detailed our previous submission, the use of agency staff is a cost effective option for hospitals, not only providing them with the ability to reduce the number of employed Effective Full Time (EFT) staff members, but also providing additional staff when they cannot meet their staffing requirements. As illustrated, the use of agency staff rather than bank staff can be a more cost effective option, with the average agency mark up around 44% and nurse banks on costs around 48%.

[2] Comprehensive statistical information is collected by the Victorian State Government on the performance of each hospital within the public health system. The Victorian State Government has released some *averaged* figures to the media, which we believe may not accurately portray the real state of the health system on a hospital by hospital basis. The RCSA has been advised that requests for access to this information under the Freedom of Information Act will not be executed within the timeframe required to respond to the ACCC. The ACCC may be able to secure this data more easily to assist with its' judgement.

Of greater expense to hospitals is the increased use of overtime. The introduction of the Directive has decreased the number of nurses who are willing to work casual shifts for only the award rates of pay. The use of overtime to combat staffing shortfalls is likely to increase if the tender is introduced with the resultant reduction in the quality of patient care and stress on those forced to work much longer hours to fill a vacant shift.

Overtime rates require that the nurse is paid from time and half to double time, depending on the nature and length of the shift. As shown in Appendix 1, the cost of an agency nurse is far less than the cost of the same nurse being paid overtime. In those cases where an individual agency may pay the nurse above the award, the agency rate is still highly competitive[4]. In addition, we are also aware that a number of hospitals pay their staff at above award rates, which further increases the costs to the hospital, makes overtime even more expensive and thus agency even more attractive as a viable alternative.

Any reduction in nurse staff costs that the Victorian State Government believes it can achieve must be offset by potential cost increases in other areas.

*Increased WorkCover and Public Liability Premiums*

With the increasing use of overtime, nurses are also at an increased risk of sustaining an injury or making serious errors that are likely to have an impact on patient care. This has the potential to increase the costs of WorkCover premiums and associated costs including public liability insurance. The costs cannot be ignored. It was acknowledged in the 'Hospital Highlights Report For Year Ended June 2001'[5] that increases in WorkCover premiums have had a significant influence on the financial results of hospitals.

*Increased Risk Of Losing Nurses Due To Injury*

In addition, a serious injury to a nurse could result in their permanent loss from the workforce. Nurses currently have one of the highest rates of injury for any occupation and this can only be further exacerbated with increased overtime. Hospitals are prepared to modify their operational practices to allow nurses to work for longer periods, when only 12 months ago this was considered unsafe and was discouraged in most hospitals.

*Increased Cost Of Hospital Bed Closures or Patient Transfers to Private Hospitals*

In addition to the reduction in patient services, hospitals are also financially penalised for bed closures or when they go on bypass. In addition, where patients require

[4] This comment refers to the free market conditions in operation prior to the introduction of the Directive. In theory, any agency that provides staff to the public hospital sector does so under a capped price structure.

[5] Hospital highlights Report For Year Ended June 2001' Prepared by The Financial Analysis and Funding Branch, Acute Health, Victorian State Government

immediate treatment, they are sometimes transferred to private hospitals, where they may be treated by agency nurses. As one agency nurse stated[6]:

> 'We seem to be getting a lot of Critical Care Services patients in our Private ICU at the moment, possibly due to closure of public beds..... It is interesting that the bill for the patients, plus a fine for not having the bed available will have to be paid by the government and the offending hospital anyway. Given that the private hospital employs an agency nurse to look after these patients very frequently, it seems a ridiculous situation.'

Ultimately, the RCSA believes that the only reduction in nurse staff costs that is likely to occur is as a result of bed closures due to lack of available nurses.

## 2. Employment Equity and Workplace Harmonisation

HPV has submitted that the tender will benefit the public to the extent that it will promote harmony and equity between all nurses in the workplace. This is incorrect.

Prior to HPV's tender submission, agency nurses and permanently employed nurses were working co-operatively and professionally together to deliver excellent patient care. Agency nurses were not, contrary to HPV's submission, vilified or victimised in the workplace. Permanent nurses welcomed agency nurses into their wards and were appreciative of the assistance and support that agency nurses were able to provide in times of extreme staffing shortages.

The Directive and the publicity surrounding the tender submission have, however, had a direct and immediate impact on the workplace environment within public hospitals. An intensive media campaign has been initiated by the Victorian Government which has misled the public, permanent nursing staff and other health professionals as to the pay rates of agency nurses. This campaign has injected tension and resentment into the relationship between permanent nurses and agency nurses where no such tension previously existed. Permanent nurses have been wrongly led to believe that the state wide shortage of nurses is largely attributable to the funds expended in engaging agency nurses.

Ironically, the tender submission and subsequent publicity have actually created disharmony in the workplace as opposed to rectifying alleged difficulties.

The Directive has also significantly increased the stress and dissatisfaction of permanent nurses who are now being pressured to work overtime in order fill the shifts previously worked by agency nurses. This disharmony in the workplace is being played out in front of graduate and student nurses and will discourage them from embracing nursing as a viable and permanent career option.

[6] Nurses name and address withheld, but available for further comment.

The problems created by the Directive provide an accurate snapshot of the practical consequences of implementing the tender. The supposed public benefits to be enjoyed under the terms of the proposed tender will not materialise and the tender will in fact increase the shortages of nurses.

We further believe that this situation is also having an impact at the graduate nurse level within public hospitals, which will have a medium to long term effect on public health.

### 3. Price Certainty

As previously stated, the tender proposes to fix prices for a 3 year period with the only variations as a result of changes to the award or EBA. While this would in theory provide price certainty to hospitals, it ignores the global nature of the market place and assumes that nurses will stay within the system when working at the award.

As predicted, we are seeing nurses move from the public to the private sector or leave the workforce in disgust at the situation. At a number of agencies, nurses have indicated that they have left nursing to pursue other careers (pharmaceutical sales, teaching etc) or are undertaking further education to allow them to leave nursing. Our survey indicated that 68% of nurses will leave the nursing profession or choose not to work any additional shifts, as they do not perceive there are any 'benefits' in so doing, thus worsening the shortages of experienced nursing staff. This trend will only be exacerbated by the tender.

As the shortage worsens, hospitals would be forced to go outside their preferred contracted suppliers or the award and that as such, price certainty could not be achieved. While the current Directive purportedly prevents hospitals from utilising nursing agencies that have stated that they will not comply with the capped pricing structure, it is our understanding that such agencies are still being employed. The exclusivity provisions of the tender will then further restrict the pool of available nurses to only those engaged by the successful tenderers.

It is a naivety to assume that price certainty could be practiced within a free market. It is difficult to achieve price certainty when there is ample supply, let alone where demand far exceeds supply.

### 4. Reduction in the Bargaining Imbalance and Promotion of Equitable Dealings

The tender submission states that the health services have little or no bargaining power in the acquisition of nurses.

Prior to the introduction of the Directive, there were a large number of nursing agencies within the Victorian marketplace and both public and private hospitals dealt with each nursing agency equitably and each agency independently structured its' pricing and operations.

While the Directive and the tender both state that they only apply to Victorian State Government public hospitals, a number of private hospitals have also requested that they be provided with the same or similar terms and conditions as the public hospital sector, as highlighted in Appendix 2. This tender, will by default, become a defacto vehicle for the collective negotiation of prices.

## 5. Increase in Nursing Staff Availability

One of the primary tenets of the HPV proposal is that if nurses are paid at award rather than above award, they will work an increased number of hours to make up for the shortfall in their income.

A number of our member agencies have acquiesced to the Directive and will provide nurses, when available and willing to work at these rates, to the public system. The following observations were made by agency members and nursing staff:

| OBSERVATION | CONCLUSION |
|---|---|
| • Given that over 1000 nurses are meant to have joined nurse banks, there should be a reduction in the demand for agency services in public hospitals. This has not occurred. | *Employing nurses at award rates of pay has not led to an increase in nurse availability.* |
| • Although, under normal circumstances it is often difficult to meet the demand, the percentage of shifts that remain unfilled has increased. This is not due to having fewer available nurses, but is due to having fewer nurses who are willing to work at award rates. | *There is a decrease in the nursing staff availability for public hospitals because agency nurses are unwilling to work at the award rate of pay.* |
| • For those nurses who are willing to work at the award rate of pay, agencies have not seen an increase in the number of shifts that these nurses are undertaking. | *Decreased rates of pay have not lead to an increase in either the number of shifts a nurse will work or in overall nurse availability.* |
| • Many nurses have specified that they will only work at the higher rates of pay within the private sector and will not practice nursing unless within the private sector. | *Many agency nurses are unwilling to work at award rates and will not practice unless they are paid at a higher rate.* |
| • Many nurses have said that they would be unwilling to work at public rates in private hospitals, if private hospitals pressured agencies to reduce their rates. | *An across the board reduction in agency rates would reduce the number of practising nurses.* |
| • Nurses are leaving nurse banks and rejoining agencies because of poor service and lack of flexible shifts that they receive. | *Nurse banks do not offer casual nurses a viable employment alternative and will not lead to an increase in the number of shifts worked.* |

| | |
|---|---|
| • To meet staffing shortfalls, public hospitals are re-allocating theatre staff to Accident & Emergency areas, although specialist knowledge and experience is fundamentally different. Nurses unhappy with this system have threatened to leave or have been threatened with termination if they complain. | *Both patient care and permanently employed staff are suffering as a result of reduced nursing availability.* |
| • The number of first year graduate nurses who are leaving the system continues to be an issue despite government claims that they are improving the nursing profession. This is often as a result of perceived poor career opportunity and monetary reward, the reduction in the number of senior staff available to act as mentors and the poor working conditions when compared with other professions. | *Due to the message which has been sent to nurses regarding their 'value', graduate nurses are leaving the system, which will decrease nurse availability in the long term.* |
| • In forcing nurses to work within the guidelines of the Directive, the government has decreased nurses confidence and optimism in how they are viewed by the community. | *Diminishing nurses confidence will reduce the availability on nurses, as nurses pursue other career options which are viewed more positively.* |
| • Full time and part time nurses are required to work additional overtime as a result of the lack of available agency resources. | *The Directive is not working.* |

In addition to the negative impact that the Directive and the tender, if authorised, would have on nursing availability, this issue is critically impacting on patient care. Based on feedback received from agency nurses, the RCSA has also identified issues of concern with patient care that currently exist as a result of the introduction of the Directive. This information is outlined in Appendix 3.

As mentioned previously, it is difficult for the RCSA to provide the ACCC with documented substantive information, however, the ACCC may be better placed to explore and investigate the issues which we have raised, utilising statistical information collected by the Department of Health Services, in areas such as:

- The frequency and duration of hospital bypass;
- The number and cost of patient transfers to private hospitals;
- The number and type of bed closures, rather than unit/ward closures
- The number of appropriately qualified and experienced staff working with Accident & Emergency units;
- The number of cubicle closures within Emergency departments;
- The number of cancelled theatre sessions;
- The number of coronary care (CC) patients requiring intensive care (IC), who have remained within CC Units due to lack of open ICU beds; and
- The length of waiting lists, by procedure.

These statistics could be provided to allow for

- a monthly comparison between the same period last year (January to May) and this year
- a comparison between actual and total capacity; and
- should be made available for each individual hospital rather than on an *averaged* basis:

# APPENDIX 1

Alleged cost savings cannot be substantiated.

Below is a costing model prepared using the average rate for grade 2 year 8 among the RCSA-Nursing Agencies SIG form January this year (Before the DHS requirement to reduce charges) showed no more that $80 000 per week savings using the figure of 1018 quoted by the government comparing the actual cost of bank to agency

Alleged Cost Savings of millions of dollars are inflated and not able to be substantiated.

| | **Bank** | **Agency** *SIG Average rate* | **Overtime** |
|---|---|---|---|
| Staff-RN Grade 2 Year 8 | | | |
| Base rate | 23.76 | 26.00 | 44.39 |
| Casual loading | 5.94 | 6.50 | |
| 8% superannuation | 2.38 | 2.60 | 3.55 |
| 3% workcover | 0.96 | 1.05 | 1.44 |
| 8% Hiring/recruitment costs | 1.90 | 2.08 | 1.90 |
| 8% Payroll /IT costs | 1.90 | 2.08 | 1.90 |
| 5% Training and education | 1.19 | 1.30 | 1.19 |
| 6.39% Indemnity insurance | 1.52 | 1.66 | 2.84 |
| 16% Call centre costs | 3.80 | | |
| 15.5% Agency markup | | 4.03 | |
| | **$ 43.35** | **47.30** | **57.21** |

*Figures above are the average rate of fifteen RCSA SIG agencies- representing 5-6000 agency nurses*

**DEFINTIONS**

Calculations based on a 7.6 hr shift

External Accounting Compliance Costs
Internal Accountant/Bookkeeper
Utilities
Allocation & Payroll staff
Telephone

*Hiring /recruitment Costs*
Costs associated with hiring new staff, police checks, interviewers, reference checks, orientation uniforms, advertising

*Payroll /IT costs*
Sourcing, installing, training staff on new allocations software, Additional Payroll costs I.e. payro staff
required to deal with the increase in staff, possibly a new payroll system, new computer hardware to accommodate the new software and addition staff, Calculating & administering Salary Sacrifice

*Training and education*
As per training guarantee - legal requirement

*Indemnity insurance*
1976 full time hrs @ 23.76 = $46950 Avg cost of Indemnity Insurance to an agency $3000pa
$3,000/$46,950 = 6.39%

*Annual replacement cost*
A full time nurse will require annual, sick and long service leave replacement Annually
Annual Leave hours = 228
Sick Leave hours = 76
Long Service Leave @ 12 weeks for 10yrs service = 45.6 hrs
Total hours 349.6 to be covered annually
349.6 hrs/ 1976 EFT hrs = 17.69%

*Call centre costs*
Allocation Staff costs, new premises for bank I.e. Royal Bank, Telephone systems, telephone costs, advertising for new allocation staff, Training on allocations

# APPENDIX 2 – AN EXAMPLE OF HOW HPV TENDER CONDITIONS WILL BE UTILISED BY PRIVATE HOSPITALS

Freemasons Hospital
*'the more caring alternative'*

A Company Limited
by Guarantee
ABN 53 074 431 708

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FmH

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18 April 2002

RE: AGENCY NURSING CHARGES

Following the State Government's decision to introduce restrictions on the utilisation of and payment for agency nursing services, this hospital has reviewed its arrangements to ensure that they reflect the changing market.

It is our view is that, at the very least, this hospital should not be paying considerably higher rates than those applying in the public sector.

I am therefore writing to advise that effective from Monday 6 May 2002 our first priority will be to employ staff only from those agencies who have either negotiated a lower rate or are paying rates close to public sector rates.

Agency nurses will remain a component of our hospital workforce but it is essential for our ongoing viability that we are paying sustainable rates into the future. We are keen to discuss any proposals you may wish to put forward and I look forward to hearing from you at your earliest convenience.

Should you have any queries, please don't hesitate contact me on 9483-3550 or Ros Pearson, Director of Nursing on 9483-3590.

Yours sincerely

**Jim Swinden**
**Chief Executive Officer**

# APPENDIX 3 – ANECDOTAL INFORMATION ON THE IMPACT OF THE DIRECTIVE ON PATIENT CARE

Over the last few months, RCSA member agencies have been in receipt of a significant amount of information pertaining to the impact of the directive within the healthcare industry. Due to the lack of available public information regarding the issue, we are providing the following anecdotal information. The Commission may be better placed to investigate the full extent of the issue.

Since the introduction of this Directive, most Melbourne and metropolitan hospitals have experienced some degree of difficulty or have had to introduce work around procedures to overcome difficulties with obtaining suitably qualified staff at reduced/award rates.

The following information is purely anecdotal and is based on allegations made by nurses, throughout all nursing sectors and all agencies.

| | |
|---|---|
| Barwon Health | • To avoid utilising specialist agency services, Barwon Health provided their staff with a 2 day crash course in the use of ventilators. The use of ventilators is normally covered as part of a 12 month Critical Care Certificate course. |
| Box Hill | • On a number of shifts, the Accident and Emergency department has been largely staffed by student or recently graduated specialist nurses, with one senior nurse overseeing operations.<br>• ICU staff members have resigned in last few weeks in protest over staffing quality and levels, specifically the use of students and junior staff, which were felt to make conditions unsafe. |
| Monash | • Has forced full time employed theatre nurses to work in A&E causing additional stress.<br>• Has had up to 50% of theatres closed at any one time.<br>• Have posters on the wall in their Accident & Emergency department apologising for the delay in seeing staff, as a result of the introduction of the Directive.<br>• Allegations the waiting list for peadiatric procedures has more than tripled. |
| Northern Hospital; | • Allegations that last night in ED they worked with only 8 nurses instead of the usual 13. The nurses were "run off their feet". |
| The Alfred Hospital | • The Alfred ICU have not closed any beds, however staff are working double shifts to keep the beds open. |

| | |
|---|---|
| | Many staff are working 14-16 hour days.<br>• Staff who are not willing to work extra shifts are allegedly being victimised by other staff for not doing so. |
| Austin | • 2 Theatre nurses resigned when told they would have to work in A&E.<br>• Allegations that up to a third of the latest graduate nurse group have left. |
| Royal Melbourne | • ICU staff to patient ratio moved from 1:1 to 1:2.<br>• Public patients moved to Melbourne Private ICU where agency staff can be used.<br>• As many as 16 operating theatre staff down on one day.<br>• 10% bed closure, 20% reduction in ED capacity, and 2 operating theatres out of 10 closed on the day of introduction of the DHS directive. |
| Royal Children's | • Allegations that on ward 6 west, 3 nurses to 21 children.<br>• Allegations nurses looking after 2 babies rather than 1 in critical areas. |