THE LEGISLATIVE COUNCIL GOVERNMENT ADMINISTRATION COMMITTEE A MET IN BURNIE COUNCIL CHAMBERS, 80 WILSON STREET, BURNIE, ON TUESDAY, 21 FEBRUARY 2012

Mr GAVIN AUSTIN, ACTING CEO, AND **Ms MELITA CORNELL**, DIRECTOR, HUMAN RESOURCES, NORTH WEST HEALTH, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Ms Forrest) - Welcome. Gavin, would you like to make an opening statement, and we will follow up with questions?

Mr AUSTIN - Sure. One of our major strategies is around vacancy control and management. We received input from the Allied Health Director that we could hold some vacancies in allied health. So we held vacancies there. It was not a matter of making anyone redundant - those vacancies were held over. That did, again, work in with the reduction of elective services around hips and knees. It was targeted to coincide with the patients that would not be receiving their hips and knees, therefore would not be requiring the physio associated with their recovery. There was reduction of staff there and the target for primary health was substantial and all we have been able to successfully do in primary health is around vacancy control.

CHAIR - What are the requirements around primary health?

Mr AUSTIN - The target that we received from DHHS was a savings of $1.9 million and we struggled to find any area of primary health where we could make substantial savings.

CHAIR - Effectively that is not on track then?

Mr AUSTIN - It is not on track. Primary health currently are $500 000 over budget and we are holding vacancies where that is possible, but in primary health there are not a lot of areas where that is possible.

CHAIR - That is $500 000 over budget before taking into account the $1.9 million savings?

Mr AUSTIN - No, that is against budget currently. At the seven-month mark we are half a million dollars over budget. Some would say that is doing well but compared to breaking even, it certainly isn't.

Mr HARRISS - So, Gavin, does that mean that the north west will need to be the beneficiary if you like of the injection of funds announced by the Premier in the mid-year financial statement.

Mr AUSTIN - Definitely. There is no scope within primary health for savings other than, as I said, vacancy management. We do have agency staff on the west coast and agency staff within King Island and wherever possible we are replacing those with permanent staff but some of that can just be an ebb and flow of circumstances. So if a miner is married to a nurse and the miner moves into the area, into the Queenstown area, fantastic, we have a nurse. But if we have four miners married to nurses who all move out to another part of

Australia we certainly have four resignations and we would have to back fill there with agencies which is something that does happen. It is just seasonal. It is an ebb and flow of nursing staff.

Mr HARRISS - So year to date you are behind the target by how much?

Mr AUSTIN - By $500 000.

Mr HARRISS - And projecting that forward to the end of the financial year it is going to be?

Mr AUSTIN - Probably $1.2 million or $1.3 million.

Mr HARRISS - Have you been able to identify whether, in the two further out years identified for the budget savings, you will be able to pick up any of that or is there still going to be a continuing hiatus there?

Mr AUSTIN - It is going to be a continual challenge for primary health. Primary health is a core service that many of us have enjoyed in the community. It is an essential service and I think you will find similar stories through the other two area health services where they did a back-to-basics budget, sort of a zero-based budget in about 2008. That took away any possible fat from primary health so trying to save money out of primary health is extremely challenging.

CHAIR - So again when we talk about primary health, some of it is funded by the Commonwealth and some of it is provided by the State. When you talk about the requirements you have what service are we talking about that you cannot cut or you believe that you cannot find any extra savings in.

Mr AUSTIN - Just the primary health nursing.

CHAIR - In the regional hospitals like Smithton, King Island, west coast, Rosebery.

Mr AUSTIN - When you review the services they are doing and the services that the community relies on there is no scope for change.

CHAIR - So we are not talking about GP services?

Mr AUSTIN - No. We do obviously have the contract for the GP services for King Island and the west coast which is part of primary health's costs but that went to tender last year so that is a recent contract.

CHAIR - We will get onto contracts in a minute.

Mr HARRISS - Just to flag something, will you be addressing your mind in any way to the impact on the health service delivery and the budget in this region once and if the new cancer unit is built?

Mr AUSTIN - Yes, we would be putting up a submission for additional funding for the new cancer unit.

CHAIR - Recurrent funding, operational funding.

Mr HARRISS - Will that then have any impact on the matters which this committee is considering and you are aware of the terms of reference with particular reference to the strategies which may impact upon the delivery of acute and other frontline health services?

Mr AUSTIN - All I can say is that we have identified what that service will cost to run.

Mr HARRISS - As the Chair has just said, that will be a request for recurrent funding. Will you be required to make any assessment of the impact on other frontline health services delivery as a result of having the cancer unit there?

Mr AUSTIN - The cancer unit would have to be additional funding.

Mr HARRISS - What about support services for -

Mr AUSTIN - Those are part of the budget. The support services, lab services - it is all built into how that budget is developed. The data for cancer services that I have seen suggest that the three linear accelerators for the North Area Health Service at full capacity will not have enough capacity for the number of patients that are needed for the north and the north-west, so that by the time ours is built there will be a population that would require the services of a fourth bunker.

CHAIR - Either here or in the north, either way it needs one more at least?

Mr AUSTIN - Yes.

CHAIR - That is the case to put for the funding, then?

Mr AUSTIN - That is the data I have seen.

Mr HARRISS - Given the absolutely stretched nature of the budget at the moment is there a possibility that the development of that facility is at risk?

Mr AUSTIN - There is two parts of that facility. The first part is the oncology centre, which would be appropriate for the north-west and the additional staff for the oncology centre we would be able to absorb within our operating budget. But if you go to radiation therapy, that is the second phase and then that is additional staff that in the model proposed by the expert committee is managed or overseen by the Northern Area Health Service.

Mr HARRISS - So it would not be an unreasonable conclusion to suggest that the very development of that facility is at risk given the difficult budget circumstances that this State now confronts? Given what you have just said, oncology is one area but other services are required, so we are talking about extra money into the system.

Mr AUSTIN - The development of the facility is not at risk -

Mr HARRISS - The capital development is a totally separate issue than the recurrent.

Mr AUSTIN - Yes. It is the recurrent for the radiation therapy that will be challenging for the Area Health Service to manage.

Mr HALL - The analogy is the new emergency department at the LGH for which, as Mr Harriss said, the capex is okay but staffing is another issue, so you are saying the same thing could apply here basically.

Mr AUSTIN - I am not necessarily saying it will be the same but it will be challenging.

CHAIR - The minister said some time ago about the cancer centre that it won't operate until it is safe to do so and it is not safe to do so until you have staff that are well equipped to run it. Are we just playing a game here?

Mr AUSTIN - No, we are not playing a game. I could answer that question in confidence and I could give you an answer as to why we are committed to building that facility.

CHAIR - We might do that toward the end of the session and anything else you wanted to discuss in camera.

Dr GOODWIN - What is the time line for the building?

Mr AUSTIN - The first part of the cancer centre is moving the road and that is actually going to coincide with a multistorey car park being built. That is programmed to start in March this year. Once the road is built and the design is signed off by the CEOs and the team from the Northern Area Health Service, then construction can start once the tenders have been finalised. The detailed design for that has commenced. Because the oncology centre is going to happen regardless, all the designing around the second floor and the third floor has been completed.

CHAIR - A car park was budgeted for this last budget.

Mr AUSTIN - Yes, it was in the State Budget. It could be as soon as six months that we commence the build for the cancer centre.

CHAIR - The car park is under construction now, isn't it?

Mr AUSTIN - What we are doing at the moment on site is creating some extra car parks because when we move the road at the North West Regional Hospital we are going to close about 40 car parks, so we have created about 60 additional ones, which are a part of healthy living; they are a bit of a walk to get back to the front door. Those car parks are almost complete and almost ready to open, so we intend to open them the same day as we close the others.

Moving on to service review and role redesign, we consulted with staff around the service reviews. I think the last one is just coming to an end now. There was lot of consultation with the staff and their managers and the role redesign, as I said, was very difficult because the North West was running quite leanly, but we have seen reductions in areas like finance, HR, quality, IT, data intelligence and our maintenance divisions.

CHAIR - So you can talk about the numbers of staff in each of those areas?

Mr AUSTIN - It is basically one or two out of each. Our target was eight staff across those admin-type areas or non-frontline areas at a reasonably senior level - middle management level.

Mr HALL - Given those staffing cuts do you see a lack of morale developing within the hospital, losing nurses to the mainland, for example, as we have had evidence has happened before. Do you see any of that happening?

Mr AUSTIN - Not because of those cuts, but closing Surgical West definitely has that impact. Closing Surgical West and not being able to bring on as many graduates as we have in the past definitely is having an impact. Surgical West was a really well run ward, fantastic staff, doing a great job. The North West was pumping through its elective services targets. They were part of that, they had a lot of good feelings; they weren't doing anything wrong and to have their ward closed is devastating. They just woke up one day and the ward was shut.

Mr HALL - So it is not just a short-term impact; it is a medium- and long-term impact that you are looking at here.

Mr AUSTIN - It is a long-term impact and already the graduates are finding jobs on the mainland.

Mr HALL - Yes, we are aware of that.

CHAIR - What about the nurses who were on Surgical West; where have they gone?

Mr AUSTIN - Some opted for voluntary redundancy because that was their preferred choice. Others were quite happy to go into Surgical Central.

Ms CORNELL - And elsewhere in the hospital as well. We held vacancies once we knew that the budget cuts were actually occurring so we could redeploy staff as their positions were abolished or temporarily abolished. We could then place them into other vacancies across the hospital. Staff were actually consulted, they were given their first choice, they all had individual meetings and we also met with the unions. They were all given their first choice of where they would like to be redeployed. Obviously their first choice would be to remain in Surgical West, but we were able to place everyone. We said, 'Can you give us three options', and they were all able to be placed in their first option, so that was good.

CHAIR - So the only registered nurses who had been working in Surgical West that left were the ones who took voluntary redundancy?

Ms CORNELL - Yes.

Dr GOODWIN - How big was Surgical West? How many beds and staff?

Mr AUSTIN - Sixteen beds were closed.

Ms CORNELL - Approximately 26 FTEs were affected.

Mr HARRISS - The capacity there is to reopen and ramp up when things turn, so how difficult will that be, given the shutdown? It is akin to shutting down a component of a factory. It's not a simple process just to press a button and it all turns back on. Have you made any assessments of what challenges that might pose to the facility and the service for the people on the north-west coast, given a time of reopening and how difficult that might be?

Mr AUSTIN - It will be challenging. The big unknown for us at the moment is what our budget will be for 2012-13. I am used to other jurisdictions and areas where you know your budget, say, by December, January or maybe February, so that you can plan. If we had a little bit more certainty around what our budget is going to be then I could answer that question more appropriately, but it is quite challenging because I don't know what my budget is going to be for 2012-13. If I knew that, I could then know how many joints I am going to do and could probably hold a lot of the staff, surgeons and nurses. The longer that delay goes on and that uncertainty continues, it gets harder and harder to recommence a machine. The surgeons are in a similar situation where they require a quantum of procedures to be able to meet the college and to train staff and be accredited. At the moment we're at the very bottom of that equation and they need more, but I can't give them any certainty until I know what the budget figure is going to be.

Mr HARRISS - Does that pose a threat to any of your accreditations or the teaching capacity?

Mr AUSTIN - It poses a threat in the sense that we could lose fantastic surgeons.

Mr HARRISS - In any particular area of speciality?

Mr AUSTIN - Orthopaedics at this stage, because it's hips and knees.

CHAIR - Were there any discussions at all, Gavin, particularly as the North West Area Health Service had got their over-boundary cases right down? There has been some suggestion, particularly with the use of the Mersey as well with the lower acuity surgery in the orthopaedic area, that there is capacity there for more surgery to be conducted through those facilities. Were there any discussions about working with the Southern and Northern Area Health Services to have patients come through this area? You would obviously have to keep Surgery West open to do that, to deal with some of these cases, or is it that they say there is no money so you can't do it?

Mr AUSTIN - There were extensive discussions, and there still are, but the challenge for the north and the south has been around the budget. If we are doing the procedures, we will need an operational cost to cover our base cost. Even if you see it as consumables only, there is still a considerable cost for each procedure.

CHAIR - So we'd have to charge those area health services for the service?

Mr AUSTIN - Yes, and at this stage they have no budget that they can apply to us. Discussions still go on on that basis and will continue.

CHAIR - We've heard evidence that some GPs out of the North West Area Health Service area have considered referring their patients in the Southern Area Health Service to the Northern Area Health Service where there is a shorter waiting list in a particular procedure. If that happens, that you get someone from the south -

Mr AUSTIN - That is happening.

CHAIR - How do you deal with those?

Mr AUSTIN - It is extending our over-boundaries, but that is happening with endoscopy currently.

CHAIR - Do you charge those area health services?

Mr AUSTIN - No, it's a referral. Those patients generally have a postcode that belongs to the north-west.

CHAIR - So they are yours anyway?

Mr AUSTIN - Yes, but they previously weren't.

CHAIR - So they've moved?

Mr AUSTIN - Their GP was referring them to a different area that now is referring them to us. They have changed their referral.

CHAIR - But it is not going the other way; you are not getting ones from the north or the south being deferred?

Mr AUSTIN - These were on the north or south waiting list and now they are on our waiting list.

CHAIR - In talking about some the barriers that you have to greater utilisation with the Mersey being funded by the Commonwealth from a bucket of money for that and also the contractual arrangement for obstetrics and ophthalmology and even that could extend out to the contract for GP services on the west coast and King Island, do they present challenges? Do we need to look at some of those things in the bigger picture, maximising the efficiency of the money we have?

Mr AUSTIN - The contract for maternity services is a contract that does not appear to have an end date to it, so that contract sees us paying the DRG or activity-based funding price to the provider of those services. That is not to say they are not doing a fantastic job, but the North West Regional Hospital does not have a maternity ward. The North West Regional Hospital's maternity ward is in the North West Private Hospital and they receive the full DRG for those services. So remodelling the maternity services across the north-west in any shape or form is inhibited extremely by that contract. So we do have to duplicate the services at both sites.

CHAIR - So in an ideal world, how would we go about making sure that we are increasing our efficiencies in that area because you say we are duplicating?

Mr AUSTIN - We could have the lower acuity births at Mersey and have higher acuity births at North West Regional. The problem for us at this point in time is that we would be paying for those births. There is no flex. If it was our own ward we could flex the ward but because we are paying per birth there is no financial reason to do that. So to make sure that the people at Mersey have safe births we have to completely duplicate the services and to ensure that service is safe for all contingencies. That means having 24/7 anaesthetist cover for caesareans.

CHAIR - And epidurals and the like. Having a contract with no end date is an interesting beast in itself.

Mr AUSTIN - It is.

CHAIR - How do you suggest that be dealt with?

Mr AUSTIN - We would like to see that contract revisited in terms of having it changed in having an end date, having a review date and having a price change, but none of those things are possible.

CHAIR - Will the activity-based funding model also apply to maternity services?

Mr AUSTIN - Yes, but at the moment all we would receive is the full DRG, which we are passing on in full to the North West Private Hospital. So any associated services with maternity that we choose to do, we have to fund out of the North West Regional Hospital, not out of the DRG for maternity services.

CHAIR - As far as the level of service required to be delivered by the provider under the contract, does that cover everything that is provided or is the North West Area Health Service required -

Mr AUSTIN - We are providing extra services, yes.

CHAIR - What extra services are you providing that are not under the contract?

Mr AUSTIN - We would do clinics at King Island, Smithton -

CHAIR - West coast?

Mr AUSTIN - Yes, west coast. Those services fall outside the scope of the contract but there is no revenue. Sometimes we have been very fortunate to pick up MSO funding, but if we do not we still have to run the clinics.

CHAIR - MSO funding is Federal or State?

Mr AUSTIN - Sorry, I do not know. I will come back to you on that. It is backfill funding, though. So you have to take a person out of their job to go somewhere and you can get funding to backfill that person. It is not always an arrangement that we could work with.

CHAIR - As far as your funding cuts, and this is where we are looking at a primary health area here as opposed to acute obstetrics or maternity services, aren't we?

Mr AUSTIN - Yes.

CHAIR - Is it classified as primary care, this MSO service?

Mr AUSTIN - But we can stretch it to include services that are deemed appropriate for the population.

CHAIR - But it comes at additional cost, though?

Mr AUSTIN - It does, you have to backfill.

CHAIR - So what about the ophthalmology contract?

Mr AUSTIN - The ophthalmology contract for the North West is a fee-for-service contract. That is more an issue for us in terms of being able to find a second ophthalmologist, so we feel we are receiving a fair fee for service. It would be great if we could have that person on staff, but there is quite a dire shortage of ophthalmologists.

CHAIR - They can name their price, can't they?

Mr AUSTIN - Basically they can dictate to us what we are paying them, but we are receiving an excellent service from our ophthalmologist. He works hard. The only problem is if he needs a holiday our patients basically do not get serviced until he comes back from holiday because we cannot get a second one. We are in a better situation than some.

Mr HARRISS - Back to the maternity services, you indicated, Gavin, that contractual arrangements do not appear to have an end date and your solution in answer to the Chair's question was that it is a necessity to revisit the contract. How practical is that, given that it is a contract without an end date?

Mr AUSTIN - It is a matter for lawyers to give me advice. Legal advice was sought two or three years ago. It is being sought again.

Mr HARRISS - The private facility, I would imagine, would not be too interested. Why would they want to renegotiate when they have an open-ended contract with a guaranteed revenue stream?

Mr AUSTIN - Again there are other solutions that we could explore, but I would rather discuss those in confidence because of the commercial nature of this. Certainly we have no criticism around what that provider is providing for us.

Mr HARRISS - I gathered by your earlier contribution that you are very happy with the service being provided.

CHAIR - It is about the flexibility across the region though, isn't it, Gavin?

Mr AUSTIN - Yes, it is.

CHAIR - Increasing efficiencies and potential cost savings.

Mr AUSTIN - Potential savings. There is no way that you can flex up or down.

CHAIR - I do not know if you are able to do this, but put a dollar figure on what that flexibility could mean.

Mr AUSTIN - Two or three million dollars

CHAIR - That would fix your deficit in primary health anyway.

Mr AUSTIN - It would definitely help, yes.

Dr GOODWIN - You say legal advice was sought two or three years ago. Was it actually received at that point?

Mr AUSTIN - I am led to believe that some advice was received and some changes were made, but still there did not seem to be any end date inserted.

Dr GOODWIN - So further advice will need to be sought and you are just waiting on that to come back to you?

Mr AUSTIN - Yes.

CHAIR - When do you expect that?

Mr AUSTIN - Within the next three months.

In terms of elective services and reducing elective surgery volumes, the North West has reduced the sessions for elective services from 30 to 25 at the North West Regional Hospital. As a result of that the over-boundaries have gone up from 10 per cent to just under 18 per cent, so it is having an impact. As we predicted, we have no flex to be able to absorb that. Some areas are still excellent and I have graphs that show that the waiting times for people in the north-west are still substantially lower than they were in 2008-09.

CHAIR - Do you have any evidence of an increase in emergency presentations of people on waiting lists at this stage?

Mr AUSTIN - No, we don't. We have another graph here of the accumulative of elective versus non-elective and it is not at this stage showing a huge difference for the two years.

CHAIR - Is it a bit early to tell because the ward closure didn't happen until just before Christmas?

Mr AUSTIN - On top of that we shut down elective services for four weeks. We did that basically as a budget savings measure but that had quite an impact on the waiting list and on our elective surgery but it definitely meant that we had beds available over the Christmas period, so there was no bed blockage during that time or nothing other than what we call business as usual.

CHAIR - You generally have a bit of a slow down over Christmas anyway, don't you?

Mr AUSTIN - We generally do but Jane has preferred to keep the machine going if you somehow managed to get elective emergency surgery going, so she thought why not, just keep the machine going and keep them working. That is why she did that but this time we decided to slow it down.

This graph is just showing you that the wait time is still a lot lower than what it had been in the past.

CHAIR - But you are expecting that to go even higher by the look of that chart.

Mr AUSTIN - It certainly is.

CHAIR - When do you expect that to become more evident?

Mr AUSTIN - It is becoming more evident each month at the moment so, as I say, we have gone from 10 per cent to 18 per cent. We should be able to pull that back a little bit now that we have started the sessions again, but for the over-boundaries for hips and knees we can't keep up with demand with the number that we are going to do.

CHAIR - Is it only orthopaedics that is the issue for the North West Area Health Service?

Mr AUSTIN - There is one other area and it wasn't to do with budget savings but it is primarily orthopaedics. The other one was around those people that were transferred from other areas for endoscopy, so their GP was referring them, say, to the north or the south. Now they have pulled back and are referring them to us so we took quite a hit on our endoscopy over-boundaries in the last three or four months, so that has seen an increase. We will be able to get through that over the next three or four months.

CHAIR - They are mostly done through the Mersey now?

Mr AUSTIN - Yes, they are done through the Mersey and we will be able to reduce that but it is definitely affecting our stats at the moment.

CHAIR - What sort of time frame are you looking at to get that back under control?

Mr AUSTIN - Three or four months.

CHAIR - That will not be negatively impacted by the budget cuts?

Mr AUSTIN - No.

CHAIR - For next year you don't know what your budget is going to be. That must make it very difficult. It seems to have been alluded to with the midyear financial report that another $25 million is needed by Health. Significant challenges to meeting those savings targets that were presented at the beginning of the financial year. The minister made it quite clear at that time that there were more savings to be made this coming financial year so is it likely to impact on other services beside orthopaedics if that is required?

Mr AUSTIN - Again, I am really dependent on the budget information before I can answer that. We were hoping that if the budget remained we are confident we would be able to do more orthopaedic surgery in the next 12 months.

CHAIR - So when do you expect it to be finalised? I know you wanted it finalised in December, but when do you expect it?

Mr AUSTIN - Perhaps April.

CHAIR - That is pretty close to the end of the financial year.

Mr AUSTIN - It is. Last year was quite late and the year before was even later.

CHAIR - It is a recurrent thing. Is it just Health that suffers this problem?

Mr AUSTIN - No, I do not think so, but under activity-based funding I suspect it will have to come forward because the THOs will need to know what their budget is to write their business plans and their corporate plans.

CHAIR - So that could be a positive outcome then.

Dr GOODWIN - Chair, could I just go back to the endoscopy referrals and just ask a clarification question around that? I think you mentioned that the north-west is getting more referrals now than the north and south, or proportionately more.

Mr AUSTIN - Yes. A GP can refer you to a consultant in the north, in the south or to one in the north-west. The GP may have referred you to one in the north because he knows that consultant, but now I have heard about the short waiting times in the north-west and you have a north-west postcode it is appropriate that the GP thinks for your sake it is better I refer you through to the Mersey. The Mersey has an excellent reputation for the endoscopy, it is a fantastic machine and gets patients through in excellent timing with very few issues whatsoever.

CHAIR - As far as patient outcomes go? That is one of the questions that we were asked earlier today, if that is the case that things are ticking over well there with their orthopaedics as well as their endoscopies, are the outcomes as good as everywhere else?

Mr AUSTIN - Yes, they are. What Mersey suffered from for a long time was the lack of permanent staff. What we are seeing is an increasing number of permanent staff at Mersey. We have never been able to have permanent staff in some areas and we now have permanent staff, but the surgical delivery has always been excellent. Now with the additional permanent staff and the North West Area Health Service providing a whole lot of area cover, the service is excellent.

Dr GOODWIN - Essentially you do not have any control over those referrals, so if the GPs obviously think it is going to be faster to refer their patients to the Mersey, for example, then they might all start doing that and that means then it puts more pressure on you to deliver within those time frames.

Mr HALL - With that graph that you tabled for us, Gavin, there seems to be a spike in both of 2009-10, 2010-11, February-March of waiting times for all categories and it is going up again now. Why is that? Is there any particular reason? Is that just a hangover from the festive season, if I can put it that way?

Laughter.

Mr AUSTIN - Yes, it is just a lack of staff at that time.

CHAIR - People take holidays, surgeons and staff. They are allowed to have a holiday once a year.

Mr HALL - Obviously during the winter months if we have a bad 'flu season and if we are already on an upward trend now, that could have quite an impact. Can that have an effect?

Mr AUSTIN - Yes it does because if we have a lot of people on a ward then we have to slow down elective services. Anything other than day surgery is going to take up a bed and if we have a bad run, as you say, around a 'flu or a gastro outbreak then we have to slow down elective services. But that is business as usual, that is what we would expect to do.

Mr HALL - If I could just digress here for a moment. We talked about the Mersey and we know that that is a Federal-funding model and I suppose you may or may not have an opinion on this but given that the Commonwealth Government would have the capacity to raise taxes and therefore revenue, do you think that in an ideal world perhaps it might be better - and it has been put to us by other people - that there should only be one single funding provider and maybe it should be the Commonwealth and the States are not involved in that respect?

Mr AUSTIN - I am not really in a position to answer that.

Mr HALL - I just though I would try.

Laughter.

Mr HARRISS - We will ask the minister what your thoughts are.

Mr HALL - We will tell her what you said.

Mr AUSTIN - Yes.

CHAIR - Gavin, I guess the term of reference is focusing on the impact of the cuts. If you had to give us a broad brush summary of how the cuts have affected service delivery and staffing issues in the hospital but also patient outcomes, can you do that, can you provide more detail on that? I know it is probably a little bit early in some areas.

Mr AUSTIN - It is because the slow-down in elective services surgery was only on 1 October and we have had this Christmas shut down, so we are still getting a feel for that. But without a shadow of a doubt, the impact has been on orthopaedic surgeons, and they would be quick to tell you that it is substantive and it is something they would like

to see changed immediately. They would like more funding and they would really like to get this back on track because, as you are aware, if you delay someone's surgery then eventually they are going to escalate in the complexity and come back to us as an acute patient with complications. So they are very fixed of the mind that we need to tackle this problem that delaying elective surgery is not a good long-term, substantive tactic.

From the CEO point of view, I have been asked to deliver budget savings. We looked at a way to do that which would have the least impact in terms of our population and we have tried wherever possible to adopt strategies that would have the least impact on our staff. There has been significant impact on our staff. In every area they have been impacted. Even the areas that are not impacted, like the DEM or the medical ward or the HDU or the ICU, they still share the same staff, they still see the pain that is being experienced across the North West Area Health Service. We are a small community, so you know if somebody has lost their job and so we all feel for them. It is a tough time for health but our projected savings for the North West Regional Hospital were in the magnitude of $12.9 million that we would have to save from that hospital. That is a huge target from a budget of approximately $100 million, it is 13 per cent. Whatever we do across the North West Area Health Service is going to have an impact on both patients and on our staff. We strive to keep them informed. We strive to, wherever possible, minimise the impact to our patients and I talked extensively to the consultants about those areas where we could slow things down without it impacting on patients and we did that wherever possible. But the quantum dollars of a single orthopaedic operation is so much that that was basically a way to achieve our budget savings. Closing one or two beds does not achieve nearly the cost savings of closing a whole ward. The impact for those staff is immense and the positive was - if there were any positives out of it - that it gave us a chance to refocus our attention on any areas where we could improve our efficiencies. As I said, with the savings around imaging and looking at different roles, how we could consolidate things, there were positives coming out of that. We are looking at paved parking but it is pretty hard to look at that while you're ripping up your road and building a new car park, so that strategy is obviously on hold until the end of that.

CHAIR - Has there been an impact on the DEM? Have the bed closures created a bed-block issue?

Mr AUSTIN - There is seasonal impact on DEM, but we haven't reduced any staff whatsoever. The impact is again on elective services as opposed to the DEM. If we have bed blockage we have to cancel sessions, so that's the flow-on effect as opposed to holding people in the DEM.

CHAIR - That's in addition to the wind-back of elective surgery anyway? So potentially we're seeing a further reduction in elective surgery because of the bed-block issue?

Mr AUSTIN - That doesn't happen very often, but it can happen.

CHAIR - You have mentioned that the orthopaedic surgeons have said they want the restrictions lifted and to get back to work and that there are implications for their ongoing accreditation with their relevant colleges. Do we have any evidence of their patients deteriorating? Have they been monitoring them more closely or are they back to their GPs for that? How are they managing those patients?

Mr AUSTIN - They are concerned that their patients aren't getting through at the same volume as soon as they would like them to. As I said, our over boundaries in orthopaedics is climbing so those patients aren't being seen within the appropriate time.

Dr GOODWIN - On that, in addition to the fact that the patient's condition might deteriorate, there is also the issue that they may be unable to work because of whatever problem they have, that means they are in the position of not being able to work for a longer period or they deteriorate and then they can't work. Is that part of the concern as well?

Mr AUSTIN - It is. The North West Area Health Service is a small community and we care about each one of these people. We are concerned for their welfare. Our orthopaedic surgeons are concerned and they are becoming more concerned. If there was a way to get more elective services money, they would take it and use it immediately to reduce our waiting lists. In Tasmania we are faced with a budget situation that requires savings so we went about this process in the most humane, compassionate way we could do it. Nevertheless, there have to be cuts, and $13 million out of $100 million is a huge cut.

Dr GOODWIN - On top of those efficiencies you said that have already been made?

Mr AUSTIN - Yes, that has been our challenge. By slowing down the elective surgery you get a slow down in the number of theatre staff you use. Whilst we may not lay off theatre staff, it means you have less pressure for overtime and less demand on agency staff. There are a lot of additional savings that come out of that slow down. We do a lot less overtime and double shifts. That has a positive impact in terms of financial negative if you're a casual relying on that work.

CHAIR - We could always use the argument, too, Gavin, that you create inefficiencies. It was Jane's view that you don't slow right down over Christmas because some surgeons and theatre staff have to be on call anyway because you have to deal with emergency cases. When you are called in for an after-hours case it is four hours double time at a minimum, or four-and-a-half I think it is now, but you are only there for a quick procedure - you can be there all night sometimes, I know - but effectively if staff are going to be there anyway isn't it better to utilise them?

Mr AUSTIN - Which is what we have tried to do, so we have scheduled sessions for acute surgery.

CHAIR - During that break?

Mr AUSTIN - Yes.

CHAIR - It is a bit hard to schedule around emergency as you don't know when the emergency is going to happen, do you?

Mr AUSTIN - No.

CHAIR - Gavin, what consultation was there between you and the department or the department and you when the decision was made that $12 million needed to be taken out of the North West Area Health Service?

Mr AUSTIN - The first consultation was to let us know what the target would be and we were encouraged to identify those savings in areas other than frontline services and areas that would not impact on patients, so that is where we devoted our energy. When we had finished those discussions clearly there was quite a considerable gap for the North West Regional Hospital and so we went back and said that we had a gap and these are strategies we could do to reduce that gap. Some of those were very precious to us. One of our strategies was to delay our implementation of an electronic record for health. That was something that we had programmed to do and we had set aside $1 million of our budget which was going towards that, so we delayed doing that this year. We still intend to do it but we won't be able to do it at the scale or pace that we would have liked.

CHAIR - The North West Area Health Service was the first area health service created, for want of a word, in the State. The north and south followed and Jane did the changes in this area, as we are well aware, and in doing so she said that she made a number of efficiencies, cuts or whatever you want to call it that meant that when you were given the task of savings that you were required to make it was much more difficult because the fat had been removed. Was that taken into consideration at all in these discussions with the department?

Mr AUSTIN - That was noted.

CHAIR - But no consideration given?

Mr AUSTIN - It was noted.

CHAIR - The rules were the rules and that was it. There was no flexibility or no allowance made then for those changes that had already been put into place?

Mr AUSTIN - I can't answer that but we did voice concerns that the North West had a substantially harder role in this than the other two health services.

CHAIR - Because you had gone first?

Mr AUSTIN - Yes.

Mr HARRISS - Gavin, you would be aware from the public coverage of the difficulties in the south over the last weekend and that in fact beds were reopened to address the issues that had arisen. If you were confronted with similar circumstances here in this region would you act similarly?

Mr AUSTIN - Yes, we would. We have flexibility to open six additional beds on Surgical Central, which are frequently opened, and we have ability to open additional beds. Again that is part of normal business for health - flexing up, flexing down. You can get a flu or a chest infection. We had three patients needing ventilation in our ICU the weekend before which is very unusual for us. That didn't cause bed-blockage but it certainly caused overtime because the staff required to care for those patients are quite expert in their field. To have three at once was quite unusual. That is a seasonal thing and something you wouldn't expect in February.

Mr HARRISS - And given Jane Holden's dual continuing role here for the moment, have you had discussions with her about what happened in the south?

Mr AUSTIN - No I haven't, but we have cooperated with the south wherever possible to repatriate people from the north-west back to the north-west to reduce the numbers in Hobart. We have been insisting in that way and making sure that we are not transferring anyone down there that we can hold up here.

CHAIR - Gavin, when you open beds - a cyclical thing that happens at other times, not just now while these cuts are being imposed - are they staffed through agency staff, overtime or how are they staffed?

Mr AUSTIN - Casuals. Because of the budget cuts there are a lot of casuals on our books now who aren't receiving the volume of work that they used to receive. We have an excellent pool of casuals so we do not need agency staff.

CHAIR - Which must be cheaper then.

Mr AUSTIN - It is. It usually means we are not having to pay overtime; it is at casual rates, not agency.

Mr HALL - With the number of hospital beds per capita, Gavin, is the north-west up to national parity, if you like? Are they better served than other parts of the State, do you think, given that you seem to be having fewer problems in some ways than perhaps the Royal and the LGH?

Mr AUSTIN - I don't know; I would have to do some research on that. We are blessed in having the two hospitals.

Mr HALL - That obviously does have some impact on elective surgery and waiting times and everything else if you have more beds per head of population. It naturally follows that you are in a better position to service the population of the region.

Mr AUSTIN - Yes, but people of the north-west are parochial as they are in other places.

Mr HALL - I'm not saying it is a bad thing if it is; it is a good thing.

Mr AUSTIN - We also have a couple of projects running. We have the NPA funding for an outreach service for our rehabilitation service, which is funded by the Commonwealth. That is a new service that again takes pressure off; rehab can be done at home as opposed to in the hospital. We also have the trial, again Commonwealth funded, for what we initially called the Gold Standards Framework, but it has a new name this week - Healthy Living and Dying Well in Aged Care. That is an initiative where we are working with patients in rest homes and we are working with the rest homes, their GPs and the North West Regional Hospital around developing an electronic record. We talk to the patient and their family about what they would like to happen to them. That plan is then documented and agreed to by all three. It is a wonderful intervention and it might save money, but it also saves a lot of heartache for the patient and for the person. You can choose whether you want to be resuscitated when you come into DEM or you can choose, 'Thank you, I would like to die with dignity'.

CHAIR - So advanced-care planning.

Mr AUSTIN - It is and it is good, and it circulates between the three: the rest home, the GP and the Area Health Service.

CHAIR - Is that just being rolled out here in the North West Area Health Service?

Mr AUSTIN - Yes.

CHAIR - Just here.

Mr AUSTIN - It is a Commonwealth-funded program.

Dr GOODWIN - Is it a pilot?

Mr AUSTIN - Yes, it is a pilot.

CHAIR - They have done it in the UK for a long time, haven't they?

Mr AUSTIN - Yes, and it is the UK methodology that we have picked up and are running with. The Royal Hobart is running a similar program as well.

Mr HARRISS - Given the demands of reducing elective surgery volumes et cetera and given the targets you were already meeting, what are the ongoing dangers to even more elective surgery services being cut at times when DEM presentations escalate?

CHAIR - Or admissions from DEM?

Mr HARRISS - Yes, the admissions from presentations at DEM.

Mr AUSTIN - I could make a flippant comment about us all moving to Melbourne. The answer is what I have articulated previously, that we would see a greater number of cases coming in acute with complications. In the end it won't be an effective intervention because it will cost you more to do the acute surgery than it would have to do it as elective surgery. It's a short-term win and long term you won't win. That is why the orthopaedic surgeons like their thoughts shared that money needs to be found for this.

CHAIR - Before we go in camera on the last couple of matters, is there anything else you would like to add?

Mr AUSTIN - No.

Evidence taken in camera.