Australian Nursing Federation
(Tasmanian Branch)

Submission for the Parliamentary Inquiry into Cost Reduction Strategies of the Department of Health & Human Services

December 2011

ANF
TASMANIAN BRANCH

1. Australian Nursing Federation (ANF)

1.1 ANF Overview

The Australian Nursing Federation (ANF) is both the largest nursing union and the largest professional body for the nursing team in Tasmania. We operate as the State branch of the federally registered Australian Nursing Federation (ANF). The Tasmanian Branch represents over 6,200 members and in total the ANF across Australia represents over 240,000 nurses. ANF members are employed in a wide range of workplaces (private and public, urban and remote) such as health and community services, aged care facilities, universities, the armed forces, statutory authorities, local government, offshore territories and more.

The core business of the ANF is the industrial and professional representation of nurses and nursing, through the activities of a national office and branches in every state and territory. The role of the ANF is to provide a high standard of leadership, industrial and professional representation and service to members. This includes concentrating on topics such as nursing education, policy and practice; industrial issues such as wages and industrial matters; and broader issues which affect health such as policy, funding and care delivery. ANF also actively advocates for the community where decisions and policy is perceived to be detrimental to good, safe patient care.

1.2 Contact Information

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2. Background

2.1 Tasmanian Health Budget

The Tasmanian Government has announced that $500M needs to be saved within the Tasmanian health budget over the next four years. Public sector job cuts will be a result of this, including frontline nursing cuts. The ANF believes that such cuts would be detrimental to the health service in Tasmania and place patient and client care at risk.

The first impact of budget cuts commenced in July 2011, and nurses and ANF have voiced serious concerns and provided solutions through the ANF Solutions paper, May 2011.

ANF has been actively campaigning against the Government's budget cuts since July 2011.

3. DHHS Strategic Direction

3.1 DHHS Strategic Direction

(As stated within their own document, Department of Health and Human Services Strategic Directions 09-12)

Our vision

High quality, safe services for the people of Tasmania when they need them, so they can live well and live longer.

Tasmanians deserve the best possible levels of health and wellbeing. They have the right to expect that when they need care, the health and human services provided will effectively and efficiently meet their needs.

To do this the Department of Health and Human Services will provide a comprehensive, high quality, safe and sustainable health and human services system within the resources available.

Our mission

To design and implement a sustainable, people-focused health and human services system which supports individuals and communities to be active partners in the management of their own health and wellbeing.

People have the right to expect to be able to access care and support when they need it, to make informed choices about what is best for them so that their quality of life is improved, to be engaged in the major decisions that affect them and be given a full and honest explanation of what happened if things go wrong.

Our strategic objectives

Tasmania already has excellent services being provided by skilled and dedicated staff. However, the profile of the population – including its age and health status – is changing, and it is important that the Department of Health and Human Services constantly reviews its objectives to ensure it continues to focus on the changing needs of the population. For the period 2009–2012, the Agency has set the following five key strategic objectives:

1. *Supporting individuals, families and communities to have more control over what matters to them.*
2. *Promoting health and wellbeing and intervening early when needed.*
3. *Developing responsive, accessible and sustainable services.*
4. *Creating collaborative partnerships to support the development of healthier communities.*
5. *Shaping our workforce to be capable of meeting changing needs and future requirements.*

In Response: The ANF and our nursing members believe that the current budget cuts will not allow the health service to live up to this plan. It appears that there is no (or little) strategic direction in the Tasmanian Health sector. Rather the health system appears to exist as a process of crisis/bandaid management with no clear state wide coordination; the strategic direction outlined in Tasmania's Health Plan is forgotten or ignored. This Plan identified that 345 additional inpatient beds and 67 day surgery beds would be required by 2016 to meet projected demand based on Tasmanian demography. The budget cuts will reduce inpatient beds by 100, this year alone.

This short sighted approach to management leads to knee jerk decisions being made which will ultimately have significant medium/long term effects on the health system e.g. loss of skill mix; prolongation of elective surgery lists which will have a negative impact upon the health and well being of the Tasmanian public. Ultimately all 'elective' surgery will be reduced to dealing only with emergency care. This change will increase pressures on aged care facilities and general practitioners – this may cynically be regarded as a cost shifting exercise perhaps but one that will ultimately rebound on the Tasmanian Hospital sector.

One difficulty which seems to exist within the Tasmanian Health sector is that change is directed from top with little input from CEOs or others. Some examples include:

- While CEOs have to work within their budgets they are often not made aware what budget they have until the year is almost over: how can you manage your budget if you don't know what it is?
- The RHH has lacked stable CEO leadership over the past 10 years. This has had an impact on long term strategic planning and management. What is so wrong with the Tasmanian Health System that the RHH has had 10 CEOs in 10 years?[1] A costly process, particularly since some changes required compensatory payouts or salary maintenance.
- Likewise middle managers (including Nurse Unit Managers) have little control over their budgets – particularly staffing as chronic underfunding of permanent positions (as evidenced by the fact there are 2,100 fixed term employees in the DHHS) has resulted in

[1] Blair Richards *Concern Over Search For 10th Hospital Chief In Past Decade Revolving door proves costly* 27 November 2011 Sunday Tasmanian.

considerable overtime including double shifts. This fact has had a major impact on the cost of providing care in the Tasmanian health system.

- Directions to rein in spending are being made late, and only when a crisis is already underway – for example a statement was made at a Statewide Mental Health Service ICC that prior to release of mental health savings directions the service had not been told of the concerns and could not achieve the savings without taking extreme measures.
- Cut backs to elective surgery will further reduce the operating budget as Commonwealth incentives exist to encourage patient throughput.[2]

3.1.1 Unilateral Direction

The Tasmanian Government consistently asserts that these cuts will not affect patient care. This claim is unstainable.[3] Delaying surgery results in a sicker patient base, and could even result in deaths that might have been preventable[4] if earlier treatment had been available.

Before these cuts 8.7% of Tasmanians awaiting elective surgery waited for more than 365 days, the second longest delay in Australia.[5] In Victoria the Government argued that nurses closing beds would cost lives:[6] in Tasmania the Government says this is not the case. One of these groups is wrong.

In Tasmania the DHHS reported that the budget blowout was due to increased service needs, the solution to that is to cut services, and it has just been reported that emergency room presentations in Tasmania increased by 1.6% between 2009/10 – 2010/11.[7] This increase is not uniform across the State.[8] Additionally in the September Progress Chart, there were 143,864 presentations to public Emergency Departments which equates to nearly 30% of our population relying on emergency care from an ED. This increasing demand has resulted in only 77% of Category 2 patients (should be seen within 10 mins) at RHH, 53% LGH and 88% at NWRH being seen within recommended national benchmarks.

Strategies implemented to alleviate the increasing demand and capacity are now planned to be axed on 2 January 2012, eg the successful Hospital in the Home (HITH) program at LGH, which commenced in 1995, where specialised nurses facilitated early discharge to continue treatment which would otherwise require ongoing hospitalisation. The service provided complex wound care, anticoagulation therapy and Intravenous medication therapy which was saving money on decreased length of stay and more importantly improving quality of life by enabling patients to have treatment at home in a less stressful home environment.

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2 David Killick *Cutbacks put skids under $150m bonus* 7 October 2011 Hobart Mercury

3 David Killick *Waiting Lists Set To Grow As Another $58m Is Axed Drastic Surgery Drastic Cuts Will Be `Clinical'* 5 October 2011 Hobart Mercury

4 Felicity Ogilivie Man with cancer waits 15 months for colonoscopy Alarm bells sound over hospital plan (an interview with patient and Dr John Davis AMA) 11 November 2011 Australian Broadcasting Corporation Transcripts. A colonoscopy which should have been scheduled within 30 days.; See also

5 AIHW 2011. Australian hospital statistics 2009-10. Health services series no. 40. Cat. no. HSE 107. Canberra: AIHW, page 35. This was the second highest after the ACT with 9.5% waiting over 365 days.

6 Kate Hagan And Julia Medew *Patients Put At Risk By Nursing Bans: State* 15 November 2011 The Age.

7 AIHW 2011. Australian hospital statistics 2010-2011: emergency department care and elective surgery waiting times. Health services series no. 41. Cat. no. HSE 115. Canberra: AIHW, p vii.

8 DHHS Progress Chart September 2011, p 4.

For 2010-11, HITH treated 96 patients, providing 1,309 care days and 1,322 home visits/ treatment episodes. These episodes will all now be additional ED capacity or remain in hospital for this treatment for longer.

In the TV series *Yes Minister*[9] the most efficient hospital had no patients and so always ran to budget. Patient presentations and increased throughput (when coupled with inadequate staffing making overtime necessary) will always increase costs.

3.1.2 Reform and Restructure

The Minister has publically advised that 150 bureaucratic positions were to be lost from the health sector and that these losses would occur prior to loss of frontline positions. This is clearly incorrect. ANF attempted, via several emails, to obtain information from CEOs and the DHHS in the form of a spreadsheet outlining the positions lost. The information was also sought from the Minister but to no avail. Finally, by way of question in Parliament, Hansard records that 69 corporate positions had been lost compared with 126 front line positions.[10]

There have been few improvements in efficiencies, restructure and reform of the bureaucracy and frontline services have been cut prior to reviewing and restructuring the bureaucracy. It is evident this must be reviewed prior to National Health Reform in July 2012 with the Minister announcing a new "Ministry". This should have been the first review, to ensure an efficient organisation prior to cutting frontline with no clear strategy or coordination.

3.2 Tasmania's Health Plan

3.2.1 National Health Reform

The objective of this Agreement is to improve health outcomes for all Australians and the sustainability of the Australian health system.

It is the view of ANF that this reform as proposed will not improve the quality of patient care or the health of the community. In fact the regional councils will have the Service Level Agreement, KPIs and budget mandated from the Minister and a potential conflict of interest arising with a single Chairperson. This will be an impossible achievement. The additional layer of bureaucracy will not improve nor make efficiencies in frontline health delivery.

3.2.2 Activity Based Funding

Activity Based Funding (ABF) is the cornerstone of the Commonwealth Government's National Health Reform (NHR). This funding is envisioned to encourage health care providers to be more efficient, tying payments (60% of the set fee) to specific procedures (Department of Health and Human Services and Commonwealth of Australia, 2010).

9 Written by Antony Jay and Jonathan Lynn the BBC Series first ran between 1980-2 and 1984.

10 Tasmanian Parliament HANSARD

According to the DHHS fact sheet "ABF is simply an allocation of funding based on what a hospital produces rather than funding based on what a hospital has historically received."[11] Surely, if a hospital has drastically closed beds (and 100 beds lost out of the Tasmanian health system is a huge loss of beds) then the level of production and therefore funding will, by necessity, decrease.

The loss of services will take years to rebuild the capacity to deliver through loss of specialised theatre nurses and surgeons, anaesthetists etc. The current "temporary reduction" as proposed in effect will be a permanent reduction of elective surgery throughput.

4. Change and Risk Management Processes

4.1 Change Management

4.1.1 Lack of Consistent Guidelines and Support

Change appears to have occurred on an ad hoc basis. There has been no true consultation with unions or staff. This is in breach of Industrial Agreements for consultation and OHS regulations. This lack of consultation and the imposition of a decision which is delivered as an ultimatum from the top down, has added to the anxiety and concern of staff. NAHS shock announcement on 1 December 2011 included intensive care beds and paediatric beds to close (with no warning) in addition to the 44 surgical and acute medical beds closing. LGH is currently running at 97% occupancy with no beds closed. Removing 44 acute beds with the daily average of 22 acute beds needed for the emergency admissions, will leave a daily crisis in the emergency department and increasing ambulance ramping. Patient care will be put at risk.

The Agency seemed to be completely unaware that they had 2,100 fixed term employees. Many of these workers have been employed on numerous contracts. They have a reasonable expectation of ongoing employment. Despite it being a significant timeframe since the announcement, the DHHS still has not developed clear guidelines for these employees to gain transparency for managers or employees. Of these 2,100 employees, of which 900 are nurses, 220 nurses are working without any contract due to the poor HR systems.

The level of cuts to be implemented continues to change and there is no evidence of any long term plan. For example, when (if) funding is to be restored, how will Tasmania recapture the skilled medical and nursing staff that it has lost during this time?

[11] Policy, Information and Commissioning Group, Department of Health and Human Services, *Activity Based Funding* available: http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0004/79024/ABF_Fact_Sheet.pdf

4.1.2 Lack of implementation of ANF Solutions

Not implementing solutions from ANF cost savings paper. Budget estimates has response to what has been implemented and NAHS response- ANF members forward a Solutions paper in May 2011 to the DHHS and Government representatives. In this solutions paper, there were 59 solutions put forward by nurses working in a variety of settings. It is disappointing to see the majority of initiatives have not been implemented. (Appendix D, Tasmanian Public Sector Cost Saving Initiatives 2011 - ANF Submission)

4.1.3 Limited Consultation

The ANF has at the bequest of members asked for documents from the DHHS on a number of occasions. The documents requested include risk assessments, Nursing Hours per Patient Day (NHPPD) information, rostering and information surrounding fixed term employment contracts.

This information has either been not forthcoming, or supplied in such a tardy time frame that it has impeded the ability of members to make informed decisions in relation to patient care and their own circumstances. Despite the commitment of the Minister to be open and transparent in relation to health care cuts[12] the vast majority of the information requested at this point has not been received. As the plan appears to be evolving on an ad hoc basis perhaps the information is not even available to the Minister!

Information often appears in the paper before ANF and their members have been made aware of changes.

ANF has written to the Acting Secretary to request risk management plans and bed management/flow plans be forwarded to ANF as two of three CEOs have refused to table, which should be signed off by all parties prior to any change process. Of most concern are the risks to Emergency overcrowding and the OHS implications and patient safety concerns. The Royal Hobart Hospital only has a draft Escalation policy to meet overcrowding and bed access block in Emergency Department.

The Workplace Health and Safety Regulations 1998 (Regulation 15 - Consultation)

(1) *An accountable person, as far as is reasonably practicable, must ensure that consultation occurs with any relevant health and safety committee, employees' safety representative or employee –*

> ***(a)*** *in complying with any identification, assessment or control provision of these regulations; or*
>
> ***(b)*** *if a proposed change at a workplace is likely to have a significant detrimental effect on the health, safety or welfare of* ***any person.***

(2) *The accountable person must give proper consideration to the outcome of any consultation undertaken.*

12 Kempton, H, 2011, Call to Explain Claptrap, The Hobart Mercury, retrieved 22 NOV 2011, http://www.themercury.com.au/article/2011/08/12/252521_tasmania-news.html

4.2 Risk Management

No business would implement such immense change without full consultation, risk assessment and mitigation and a clear strategy.

The Acting Secretary, Greg Johannes in a letter to CEO, dated 7 November 2011 has requested "that you have documented support from the relevant clinical and non-clinical workforce that these strategies can be implemented without risking patient safety". ANF does not support these budget initiatives selected as it will put the health of our community and patient care in jeopardy and without clear risk mitigation and consultation, leaves the Government at risk of litigation.

4.2.1 Financial Modelling and Lack of Data

IT and data is very poor within the DHHS. This is acknowledged by managers and cannot be relied upon for decision making.

It has been recently reported that the DHHS has cut up to 42 employees in the IT section where 67 people were currently employed.

4.2.2 Litigation

There is a highly likelihood of potential costs/liability of subsequent negligence claims resulting from the adverse outcomes or mortality of a patient which will be directly related to the nursing staff who have been placed in the position of having to nurse people with conditions they have no experience in, without the support of skilled staff on their units . A range of potential risks to patient care and client care in mental health has been highlighted by nurses. This is a clearly foreseeable risk.

ANF has written to the Premier, 6 December 2011, to seek indemnification for all nurses working in an environment of foreseeable risk to patient care due to the budget cuts. Presently the granting of indemnity is discretional upon application and consideration under the terms of Ministerial Direction 8. Despite the Premier making claims in the media that it was a "furthy" and nurses are covered, ANF members have had indemnity refused by the MD8 Committee and ANF will seek a retraction of this public comment misleading the community and the nursing profession or calling on the Premier to grant an exemption from the MD8 process for nurses.

4.3 Project Management

Countless hours (and considerable dollars) have been spent planning projects that were never, and are never going to happen. It has been reported there is a $17 million budget over run in external consultants' fees this financial year totalling $37 million. Many reviews are undertaken with no publication or transparency of recommendations.

Millions were spent on the Ernst Young review of DHHS services with no apparent implementation of change to improve systems. The Richardson Report strongly recommended to nurture Tasmanian graduates, the Tasmania Health Plan; and the list goes on.

4.3.1 Infrastructure

The Tasmanian health system and its buildings have gradually been deteriorating without an infrastructure strategy. The Commonwealth provides funding for building, but clearly, staffing will be decimated due to budget cuts and most new buildings will not be staffed.

4.3.2 Logistics

ANF has received many comments from member regarding on ongoing waste within the DHHS:

> *"The cut backs into the provision of ward pantries and the affect this is having on feeding patients post operatively after hours when no food provision is available and has to be borrowed from other units taking time to organise and food away from other areas, also impossible to cater for specific dietary requirements after hours if food cannot be stored on the unit that is obtained when the kitchen is actually open."*

> *"We dispose of scissors and artery forceps and dressing materials which once were recycled. Also patients used one towel and face washer which was kept by the bed to dry and reuse per admission and only changed when dirty. Bed linen was only changed when dirty or the top sheet was used for the bottom sheet. Also kylie's or pinkies used in the past, stop a lot of extra linen being used. Now the whole bed has to be changed not just the kylie."*

5. Workforce Management

5.1 Workforce Planning

For all the 'talk' about workforce planning there is little evidence that any planning or organised approach to staffing has occurred.

Apparently there are, at the RHH, 290 nurses on Fixed Term Contracts despite 65 permanent vacancies.

Losing skilled nurses and medical staff will have a long term impact on the workforce. With National Registration, workers who move interstate for job opportunities are unlikely to return. Others will be deterred from applying for positions in Tasmania for many years because of uncertainty.

In 2009 – 2011 Tasmania has had to employ trained and highly skilled nurses through agencies. In a bid to curb this expenditure, active recruitment was undertaken, which attracted a number of people on 457 visas. They are competent, trained and willing to work, but as they are on fixed term employment, as of December they will be unemployed and seeking jobs interstate. Recruitment in the future will be tainted by their experience.

Our nursing workforce is ageing. The average age of the Tasmanian nurse is 46.5 years, which is the oldest nationally. It also means many of our nurses are nearing retirement age.[13]

[13] Australian Institute of Health and Welfare, Nursing and midwifery labour force 2009

Nearly one in four Tasmanian nurses are aged over 55 years, while only 3.3% of our nurses are less than 25 years of age.[14]

Health Workforce Australia has prepared workforce modelling for each state and this has not been released yet, and is due for MINCO consideration in December 2011.

5.1.1 Overtime

Overtime is worked frequently across the service. This occurs in all wards and units but most often in Intensive Care areas. This is due to high patient occupation as well as patient acuity. The fact that establishments are often not filled (or the areas have not been appropriately benchmarked) has added to this problem.

Overtime has become an expected way of managing workloads. It is expensive to manage areas in this way. It is also not good for the health of Tasmanian nurses. Overtime may be up to 17 hours straight for double shifts, commencing at 2.30 pm (1430) and finishing the next morning at 8 am (0800). Double shifts are still being worked on a daily basis across Tasmanian public hospitals and in some specialised areas eg Neonatal Intensive Care (NICU). Overtime is daily, and yet the DHHS are not going to continue the qualified nurses on fixed term contracts in NICU. The RHH Director of Nursing (DoN) went to Ireland last year on a recruitment drive!

The reliance on overtime has also meant that the State Government has a $6,000,000 accrued liability for annual leave not taken (by nurses) which has seen them offer to 'pay out' nurses for the balance of some of their leave. This is another indication that staff management has been poor.

The ANF has attempted to address this issue. Nurse Unit Managers (NUM) have also put forward business plans providing evidence that appropriate staffing would reduce costs.

It was agreed, during the last EBA negotiations, that any double shift would be recorded as an incident on EIMS. There has been manipulation of hours worked so that the overtime falls short of a 'double shift'. However reports to date indicate unacceptable overtime and minimal remedial action or root cause analysis.

5.1.2 New Graduates and Transition to Practice

New graduates are less expensive to employ. Compared with senior nurses they can save the organisation money. Failing to bring in new graduates has two immediate consequences:

1. Nurses are not able to obtain the skills they need to work in the acute sector; and
2. The employment demographic remains skewed to the RN with 6+ years of experience.

There is a cost involved in supporting these new graduates. However, this is a short term cost when considering there will soon be a need to replace nurses who are looking to retire in the next few years.

[14] Australian Institute of Health and Welfare, Nursing and midwifery labour force 2009, excel table 5

A large number of 2011 graduating nurses in Tasmania will not be recruited into Tasmanian hospitals for the transition to practice programs in 2012. Nurses about to finish the 12 month Transition to Practice Programs will not have ongoing employment in Tasmania in 2012. All the investment in education, training and mentoring these nurses is wasted to this state. These nurses will leave and probably not return to the Tasmanian health system. Queensland has been doing some workforce calculations and estimate that they will need 14,000 nurses by 2014 – to replace those who reach retirement age as well as because of workplace demands. Tasmania has no long (or even short) term vision for renewal of the nursing workforce.

There are presently over 1,000 students of the UTAS Bachelor of Nursing course and over 100 Enrolled Nurse students. Those studying are concerned for their future employment opportunities and their career pathway in Tasmania.

5.1.3 Skill Mix and Skill Loss

The Tasmanian health system is going to lose many well qualified nursing staff. These include, but are not limited to nurses who have skills in renal, paediatric or intensive care. Replenishment of these skills will not be easy. While other nurses might ultimately be up-skilled to replace those who are lost this will place even further pressure on workers who will be required to bear the brunt of additional responsibility while simultaneously providing education to less qualified staff. This situation may also mean that people with permanent jobs within the system may decide to move elsewhere.

In addition, failure to bring in new graduates means that the nursing population will continue to be skewed towards more senior experienced nurses/midwives. This is more costly in the long term.

Loss of experienced staff will also make the implementation of positions such as Assistants in Nursing more difficult as the skill mix will be unable to support workers who have no acute care experience.

5.2 Benchmarking/Safe Staffing

5.2.1 NHpPD

Many areas within the state service have not been benchmarked for safe staffing levels, or need to be re-benchmarked because of changes in service delivery or acuity. This model of workload management and safe staffing arises from the Nurses (Tasmanian Public Sector) Enterprise Agreement 2007. The DHHS has not been committed to the NHpPD process – a process which, if implemented appropriately, would have given information about the true staffing establishment needed for a ward. As noted above, inappropriate staffing levels has led to the need for many hours to be worked as overtime.

If the staffing cannot be met or if the funding cannot be provided for positions then the DHHS has the opportunity to close beds. The NHpPD process gives the DHHS power to ensure staffing/patient needs are met. Closing beds on an as needed basis to meet staffing availability would have reduced the overtime budget and would have increased the ability of the various major hospitals to come in closer to budget.

5.3 Employee Relations

5.3.1 Fixed Term Contracts

For many years the DHHS has used fixed term contracts to fill positions yet these fixed term contracts have not always been used in accordance with the State Service Act. Fixed term contracts are supposed to be limited to positions which are needed on a short, fixed term only. Many nurses have had more than three fixed term contracts. Where the nurse obtained the position through means of appointment other than through advertising and interview the DHHS is now attempting to deny these people ongoing employment.

The Agency has identified 2,100 workers who are on fixed term contracts: 900 of these are nurses.

This situation has arisen due to the difficult HR systems which take up to three months to employ a nurse permanently. However, to avoid this impossible situation to manage rosters, Nurse Unit Managers have employed nurses on fixed term contracts, where they can commence on a roster immediately. Ongoing rolling fixed term contracts are a normal method of employment, however these nurses will now be penalised and the majority will not have ongoing employment.

5.3.2 Morale

Staff morale is at an all time low. Despite these difficulties, nurses have always provided a good service, and are now looking at uncertainty in employment. People who have made their homes in Tasmania are looking to leave the State. They advise ANF that they have told colleagues that Tasmania is not a place to seek employment within the public health sector. See Appendix B (ANF Member Comments Regarding the Parliamentary Inquiry) and Appendix C (ANF Website Comments).

5.4 Recruitment and Retention

Members are concerned that the cuts to services will have a negative impact on the ability to recruit and retain health care professionals. The reduction of experienced staff via redundancy may result in a skills imbalance, reducing the Agency's ability to provide support to new staff members or those moving from one clinical area to another. Chang and Daly (2008) identify mentoring as an important aspect of retaining clinicians in that, in addition to

providing a positive influence, the employee feels valued and gains insight into the corporate knowledge.

Loss of qualified specialist and emergency nurses from Tasmania who are currently on contracts that are ending will drastically impact on timely and quality care.

The Government should look to fill all permanent vacancies in the agency – a predicted and supposedly known cost in the budget, and then look at what is left over before failing to renew contracts of fixed term employees. It is surprising that prior to redeploying nurses working in areas targeted for closure. The DHHS advertised this weekend (Saturday 3 December 2011) for vacant position at the Mersey.

Building the confidence in the potential workforce to recruit in the future will be harmed to a point where we will not be seen as a favoured employment destination. Graduate and other fixed term contracted nurses face the decision; remain unemployed (or under-employed) in Tasmania or leave. The migration of skills out of Tasmania will be of significant cost to the State economy for years to come. Other states are welcoming Tasmanian nurses.

There is already a serious problem with recruiting nurses to the area of Mental Health and other specialty areas.

As an example: Adult Community Mental Health Services (North West) currently has approximately 30 people on an allocation list. The services have already, or are losing 1.6 FTE positions from case management, which will add potentially another 20 to 30 people to the allocation list. It has been identified that these people are too unwell, or too much of a risk, to be discharged from Mental Health Services, however due to limited staff they cannot be managed actively.

The Area Manager has identified another 4 FTE positions in Adult Community Mental Health to be abolished. Each FTE has a case load of approximately 20 people with a mental illness.

Thus the number of people in the North West who have a major mental illness but are not able to be managed appropriately could blow out to 100 - 110 people.

5.5 Education

There is a concern amongst members that the reduced number of beds and a loss of skills brought about by senior practitioners leaving will have an impact on the sector's ability to provide clinical skills.

Loss of educators is another short sighted policy. Educators do much to support new staff as they enter the workplace and to maintain the skills and competencies of more experienced staff. Despite the value of educators, business cases for replacement of the positions when the incumbent is on leave are often rejected. If lesser skilled nurses are going to be replacing specialists then there is an even higher call for clinical educators.

The LGH is not replacing the Emergency or Intensive Care Nurse Educators early in the New Year, despite the majority of new Doctors and a few new nursing graduates commencing. In addition, some nurses will be new to the environment having been redeployed from closed wards.

5.6 Managing the Establishment Numbers

Management of the establishment numbers on a cost centre spreadsheet is inefficient. The ANF has raised this as a concern on many occasions. Funding to an establishment number rather than to a personal employee number presents a number of problems including:

- Rigidly puts the funding against the establishment number;
- Promotes manipulation of the establishment and allows scenarios where more than one person (body) is in one position and subsequently leads to unfunded positions as 'bits' of FTE are lost;
- Can also make it difficult for managers to ascertain the true FTE;
- Encourages multiple fixed term positions thereby raising issues of industrial permanency;
- There are difficulties/problems when an employee is assigned to more than one establishment.

It was the understanding of ANF that managers were to be given more control over their establishment in order to be flexible with staffing to reduce overtime budgets.

The current method of vacancy control employed by the DHHS encourages wastage making it difficult to fill vacancies and contributing to an environment where nursing staff have to work double shifts to meet patient needs. Research indicates that where bureaucratic systems make it challenging to fill vacancies or employ casual nursing staff there is an increase in overtime worked that directly impacts on operational costs.[15] One study identified that it was far more effective to identify areas where overtime was in high usage and utilise those funds to create extra full time positions to alleviate burdens in work load and budget.[16]

In the absence of appropriate staffing, cessation of overtime is only possible if patient clinical services are drastically cut. This is the approach taken by the Government.

6. Impact on Service Delivery

6.1 Patient Care Across Specialities

As noted above the measures implemented will have a dramatic consequence for care delivery. ANF raise a few specific examples where 'cost cutting' may ultimately result in increased costs.

6.1.1 Emergency Medicine

Emergency presentations have been increasing over the past four years, and there is a need to maintain the qualified staff to cope with this increasing demand for emergency department services. This is a worldwide issue due to reasons such as lack of affordable

15 Drebit, S, Ngan, K, Hay and Alamgir, H, 2010, Trends and costs of overtime among nurses in Canada, Health Policy, vol 96, no1, pp 28 – 35.; Montour, A, Baumann, A, Hansberg, 2009, The Changing Nature of Nursing Work in Rural and Small community Hospitals, Rural and Remote Health, http://www.rrh.org.au/articles/subviewnew.asp?articleid=1089 retrieved 22 NOV 2011.

16 Drebit, S, Ngan, K, Hay and Alamgir, H, ibid.

after hours care in the private sector, patient self-referral to avoid the cost of the service, ease of access to emergency departments, and increasing population especially the elderly needing complex care. Emergency services, along with GPs, will bear the brunt of these cuts.

Closure of beds will increase length of stay in ED and demand will not decrease, only the supply of beds.

LGH ED is central to the coordination of serious incidents across Northern Tasmania; retrieval and evacuation. There is no capacity for LGH ED to go to bypass. In a major emergency it will be very difficult, if not impossible, for the service to effectively cater for multiple injured persons.

Appendix A contains a submission forwarded to ANF from the Tasmanian Branch of the College of Emergency Nursing Australia.

6.1.2 Emergency Theatre Lists

Since the budgetary constraints have been introduced, members working in theatre have already reported an increase the number of emergency theatre being conducted. At the NWRH theatre staff now schedule a daily period of emergency theatre. Ironically delaying elective surgery will have a direct impact on the amount of emergency surgery done and the associated cost.[17]

6.1.3 Renal Nursing

Understaffing and increased demand has resulted in an increased cost due to increased reliance on Renal Nurse on call. While there is a Renal nurse On Call the current protocol saves the LGH a call back (4 hours pay at double time = 8 hours pay) by the Ward 4D nurses going to ED. This is an important initiative especially after hours. Ward 4D is targeted to close.

6.2 Infection Control

There is direct evidence linking increased infection risk and increased patient cost with delaying elective surgical procedures. Infection continues to be a major factor in morbidity rates in postoperative patients despite the implementation of educational programs, clinical guidelines and hospital policy. The study found that patients whose surgery was delayed were up to twice as likely to develop an infection post operatively. The delays led to a significant increase in costs in some cases up to a third.[18]

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[17] Randall, J, Singh, B, Warren, B, Travis, S, Mortensen, and Gorge, B, 2010, Delayed surgery for acute sever colitis is associated with increased risk of postoperative complications, British Journal of Surgery, vol 97, no 3, pp 404 – 409; Vogel, T, Dombrovskly, V and Lowry S, 2010, In Hospital Delay of Elective Surgery for High Volume Procedures: The Impact on Infectious Complications, Journal of the American college of Surgeons, vol 211, no 6, page 784

[18] Randall, J, Singh, B, Warren, B, Travis, S, Mortensen, and Gorge, B, 2010, Delayed surgery for acute sever colitis is associated with increased risk of postoperative complications, British Journal of Surgery, vol 97, no 3, pp 404 – 409; Vogel, T, Dombrovskly, V and

7. Staff Issues

Many staff issues have already been addressed previously in this submission.

7.1 Workload

The significantly increased workload of operating a high volume short stay unit in terms of actual nursing, but also non-nursing duties that have to be attended in order to make a unit function, such as cleaning beds, filing, and answering the phone - no extra staff have been provided. Also, nurses spend a lot of time escorting patients to and from recovery and are thus off the ward causing reduced staffing numbers to look after more post operative patients.

7.2 Staff Movement

There has been a lot of staff movement, putting clinicians in areas where they do not normally work both in terms of physical location and clinical skills and in some circumstances leaving less staff to do the same or more clinical load than before. This increases the risk of errors, particularly medication errors.

8. ANF Solutions

8.1 Stop the crisis management and do not close beds and mental health client services this financial year but enable appropriate restructures to be implemented for real cost efficiencies. However, elective surgery throughput and reduction should be confined to day cases initially and other non frontline agreed efficiencies to continue.

8.2 Communicate with stakeholders, unions and the public. Don't 'drip feed' information to tell people what is happening. Allow for frank and open consultation to occur.

8.3 Re-prioritise 2010-11 funds, (total cost for bed closures is $21.7m) to maintain ongoing service to enable a timely restructure of Department and strategic plan development and risk management for short and medium term to be implemented. This may involve a roundtable of all stakeholders to review all consultants' reports and strategy which may result in a change of services to some areas, eg cannot reduce costs while still offering all services to all areas.

8.4 Urgent review of potential revenue-raising through Commonwealth funding, eg mental health credential nurse fees (currently not being accessed), lobby for Federal Funding.

Lowry S, 2010, In Hospital Delay of Elective Surgery for High Volume Procedures: The Impact on Infectious Complications, Journal of the American college of Surgeons, vol 211, no 6, page 784

8.5 Restructure DHHS and remove systems which obstruct, including HR controls, in preparation for Tasmanian Health Organisations. Once implemented at commencement of next financial year, this will give you time for strategic service modelling and planned change management with true consultation with clinicians will be able to occur. Clinical and operational risk management will be safely undertaken concurrently.

8.6 Improve systems to find efficiencies eg tender, goods and service etc.

8.7 Clear workforce planning to ensure a sustainable workforce in medium term.