THE LEGISLATIVE COUNCIL GOVERNMENT ADMINISTRATION COMMITTEE A MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART, ON FRIDAY 16 NOVEMBER 2012.

COST REDUCTION STRATEGIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Dr GRAEME ALEXANDER, MEDICAL PRACTITIONER, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Forrest) - Welcome, Graeme. You are aware of how the committee works. Everything you say is recorded on *Hansard*. It is covered by parliamentary privilege while you are here but everything you say outside may not be.

We have only half an hour with you. What we would like to go through is a bit of an update. Last time you spoke, the cuts were only just starting to have an impact on services, particularly the elective surgery aspect. We are keen to hear from you as to what it is like now as a GP with patients who are being put off. Is that really happening as you suspected it might?

Dr ALEXANDER - It has of course got much worse.

CHAIR - Would you like to update us then as to where we are at?

Dr ALEXANDER - I nearly said no to coming today because I have been to the Senate to the Productivity Commission three times and this is my third time with the Legislative Council and all along we were hoping that - not you people - governments would fix the problem that we face. When you look at it, we are here discussing whether the government has actually killed health care off altogether. That is really what we are discussing.

I think I was quoted the last time I was here saying that health care was a dog's breakfast. It remains a dog's breakfast, a messier dog's breakfast than it was before. There is just less in the bowl. That is what we are dealing with. I will give examples of things. The whole profession, whether it be nurses, allied health, specialists or GPs, the morale has hit absolutely rock bottom in every corner and you can't go anywhere without the immediate conversation swinging to 'What's the point?'. I believe morale has got to such a level across the board that we won't recover.

The impacts have produced immediate but long-term effects and I am happy to answer any questions. I am also happy to give examples but it is just a dog's breakfast, worse than ever, the whole health system. I will just briefly harp on which I did last time. We had a health and hospital reform in this state that was signed off on, and it was portrayed as the biggest reform since Medicare. It was going to guarantee hospital funding from now and into the future. That's a quote, not from me, but from health ministers and prime ministers. It was going to guarantee adequate doctors and nurses now and into the future. Already we have had to scramble to throw - I think - $325 million. If anything

puts it up into lights that the health and hospital reform is a failure, that must surely underline that it's a complete failure. What happens after the four years when that runs out? It hasn't guaranteed anything. The whole system is collapsing, state and federal. I am a bit different to some of the others you'll see today. I still say the GPs are in the best position to view the whole thing because we deal with every section of the health workforce; we also have to deal with state and federal issues. It's all mixed in together and it's often difficult for me to separate one from the other. I am prepared to give examples and I would love some questions.

CHAIR - Correct me if I'm wrong, but the challenge is the constant cost-shifting that goes on between what's federally funded and what's state-funded; the health and hospital reform just shifted the deck chairs from 40:60 funding to 60:40 and put a new framework around the THOs and activity-based funding, which hasn't started yet.

Dr ALEXANDER - That 60:40 or 40:60, I don't think anyone can know what the percentage is. Our surgery is bombarded by work sent to us from the Royal so that the Royal doesn't have to foot the bill. It has got worse. It's medications, X-rays, ultrasounds, re-referrals to specialist clinics. I think I talked about this last time. Most of the cost-shifting is hidden.

CHAIR - Why do you say it's hidden?

Dr ALEXANDER - How do you put a figure on someone coming to me so I can order all the X-rays and blood tests that previously would have been efficiently ordered in a clinic at the Royal and followed up in a clinic at the Royal? They would now come to me, and I can guarantee they will lose 50 per cent of the results we send, and 50 per cent of the referrals they won't have at the clinic on time. The whole system is collapsing around our ears with this huge cost-shifting. I don't know how anyone could put a figure on that.

CHAIR - I guess you have to cost all the tests you do, but you could argue that having your GP do all the preliminary testing, X-rays, blood tests and post-op follow-up, we should get people out of the acute setting as soon as possible into the care of their GP again.

Dr ALEXANDER - Spot on, but if there was communication between us that would work well. We're frequently asking patients what they need done because we have no communication of why they're there.

CHAIR - So discharge summaries still aren't flowing?

Dr ALEXANDER - Discharge summaries have improved somewhat in that a slightly higher percentage are now typed and readable. I am going to digress for a moment and talk about one case I think covers everything we're going to talk about. It's a 74-year-old lady at our practice. She's been coming to our practice for 10 years so we probably all know her but one doctor in question knows her medical history and family situation. She was independent a year or so ago. From increasing severe pain in her hip she is referred to the clinic and needs a hip replacement, recognised by everyone. Her pain gets worse, she can't manage and her daughter has to give up work to move back home to look after her. We are now moving into the economics of all this, not just the patient concerned. She has numerous GP appointments. She has increasing pain relief and screams out at night. She admits she would take her life if it didn't upset the rest of her family. She has

pre-existing bowel disease, she gets more pain and needs stronger pain relief. I am talking dozens of visits here and dozens and dozens of prescriptions.

CHAIR - She's on the list for a hip replacement?

Dr ALEXANDER - She is on the list. She was streamlined to a specialist; she finally gets to the specialist clinic, which is the massive hidden wait. It gets touched on but I don't think people have any idea how frustrating and long that wait is.

Dr GOODWIN - This is all happening before she even gets to the specialist?

Dr ALEXANDER - Yes. She finally gets to the specialist and the specialist says she needs a hip replacement and she will be much better - it is obvious. He expresses to her that she will have a very long wait. She asked how long and he couldn't answer that question. The reason he couldn't answer that question is that it is four to five years, if ever. Frequently specialists in clinics now are saying or we get quoted by patients saying, 'I don't know why I work at this place'. Frequently specialists tell their patients to get private health insurance because there is a 5-10 year wait but you only have a 12-month wait with a pre-existing condition on private health [insurance]. It is fascinating when our Premier says to everyone that you should go out and spend to boost the retail industry. Well, I live in the real world and I connect with the public and I tell my patients to save for your private health insurance. You are going to need it and you are going to need it more and more as time goes on. Don't go out and boost some big retail shop. Save for private health insurance.

Mr WILKINSON - Graeme, there is a story that has come to me recently and you can say whether it is consistent with what you are hearing. A lady was being treated for cancer. She had an operation, she then had some more blood tests. This was a couple of months ago now. She was found that those blood tests showed that she more than likely had the cancer return. She can't get to a doctor until I think it is February -

CHAIR - A specialist.

Mr WILKINSON - A specialist - I won't mention the specialist's name - until late January-February next year. Therefore, they have found that the cancer has come back but there is a wait of three to four months prior to her being able to go back to the specialist to see whether it has come back, and then she would have to wait after that for the operation to occur.

Dr ALEXANDER - I don't mean to be flippant but that is what we deal with every day, and it is frustrating and exhausting. Not just for us but patients. Imagine patients and families, it is just what we deal with. We can be fairly certain of a diagnosis. I think I talked about that last time - gallstones, cancer, you name it, we are fairly certain. In this case, this patient needs a total hip replacement. A first-year medical student could come to that decision looking at an X-ray from the other side of the room, but it is the wait. You just have to sit and wait it out.

CHAIR - In the case that Jim just mentioned, it will require surgery potentially but it's more a medical assessment that this patient is waiting for.

Dr ALEXANDER - It might be surgery, it might be chemotherapy, it might be radiotherapy.

CHAIR - Most of the cuts seem to hit elective surgery and the closure of beds. It is the cuts there that are causing this sort of problem as well?

Dr ALEXANDER - I think the cuts have hit everywhere. I don't think you can isolate it.

CHAIR - I'm interested why we would see a patient in that situation being put off so long to see the specialist. The specialist is not, in her case, waiting for a bed - at this stage. Maybe she will need a bed.

Dr ALEXANDER - The only way as a GP is you somehow have to cut through the red tape and the paperwork and you have to cut through to the specialist who might be involved. It's the only way. There is another way, that I will talk about later, that you can get through. The only way is if you can cut through and get to the specialist and say I have this, this and this and this is all this patient needs, can you help.

Mr WILKINSON - The other exacerbating part is that has caused anxiety and so, as a result of that anxiety it has caused some depression. It has to be treated for the anxiety and depression as well as for the matters that I was speaking about earlier on. The cost of that obviously is far more than what it would be if you were able to see somebody and get onto it straight away.

Dr ALEXANDER - The cost is huge. So this lady needs stronger pain relief, surgeon again, a letter from the GP to the specialist and the physio begging for help for this lady. The physio says, 'I can't do anything'. We have got physio visits here, I am not winning. Back to the specialist. The physio said the patient is now on two elbow crutches shuffling around her house. No response to the letter, which I have a copy of here, from the GP to the clinic asking for more help. Anti-depressants, which Mr Wilkinson was talking about, more pain relief, no action. Medication eventually causes a bowel obstruction. It is obvious this lady has pre-existing bowel disease. What does the GP do? I recently watched a program on television talking about GPs prescribing opiates in large quantities and I'm sure it happens excessively in lots of areas. Not once did they raise the fact that many of these people wouldn't need them if our public hospital systems across this country were actually working. This lady gets admitted to hospital with a bowel obstruction, she was admitted from 18 June to 30 June. So she is in for 13 days with a bowel obstruction.

CHAIR - As a result of the opioid analgesics.

Dr ALEXANDER - So she has a blockage. The only correspondence from that hospital to our surgery - and I will remind everyone we are still looking after this person and their family; we have been looking after them for 10 years - is two words: a date in, a date out, and bowel obstruction. No mention that this lady needed a laparotomy. No mention that this lady spent a long time in the high-dependency ward. No mention that she went into renal failure while she was in. Nothing. The patient, as she is leaving the hospital, is told, quote, nothing to do with her hip which is the whole problem: 'Please don't get constipated again.' That's the only advice she is given: do not get constipated again. Well, how do you do that when you are taking large quantities of pain relief and you are bedridden? It's a double whammy; she can't move, one of the major causes of

constipation, she no doubt feels sick all the time and she is on opioids. The GP then writes a letter, which I'm going to read part of - I realise we are short of time:

> Mrs X was recently an inpatient for 12 days with a bowel obstruction, which required a laparotomy.

This was on 30 August. This is addressed to Medical Administration and the Department of Surgery:

> This was apparently (as I received no detail of her admission apart from the sheet which said she went in and came out) then complicated by renal problems and a stay in the high dependency unit. The reason she has developed bowel obstruction is because she had opioids and anti-depressants for pain relief for severe hip pain. This lady is on the waiting list for total hip replacement. She is in severe pain, she calls and screams out in her sleep and is housebound. I would appreciate if you could review her position on the hospital waiting list. She will likely otherwise re-present in the system with more expensive complications of narcotic pain relief in the elderly.

As of this morning, there has been no response, nothing, from anyone.

CHAIR - Graeme, when this issue was raised and it's this sort of scenario that we said, I said and other health professionals said, will happen, the minister's response and the government's general response was: if you have people presenting to your office - which I am sure we all have, I certainly and you to your surgery - we should encourage the GP to write such a letter.

Dr ALEXANDER - Waste of time. You just do it because what you should do and it's what you are trained to do, and you are trying to do the best for your patient; a complete waste of time. I mentioned earlier there is one other thing I could have done, and it was in the media. I got a firm offer from the health minister's office, if ever I have any problems with a patient that I feel the need to go to the media or politicians about, that I just have to ring the minister's office and, quote, 'we'll fix it.' That was put around in the media because I was offended by that.

The reason I was offended is that they would think that we were that type of people that we would do that - yes, in this case we probably should do that now - but this is hundreds. I can't do hundreds. The other doctors in my surgery laughed and said, 'We are going to send all our difficult ones to you, Graeme, and you can channel them through the health minister's office.' It's pathetic.

CHAIR - What does that say about every other person all around the state?

Dr ALEXANDER - It's pathetic. So this lady - I use the term 'dogs breakfast' and I have used this term probably three or four times in the past, it is a dog's breakfast. There is economics here, there is pain and suffering here and it underlines that there is no policy, no idea, no direction from anywhere. The fact that we are reducing money from it is just less in the bowl. It is just less in the bowl, more problems, but again there are so many issues here. You hear the specialists and the GPs thinking, 'Why do I do this job?'. The

physio - same thing. The nurses looking after this lady - imagine what they are thinking as they are sucking up faeces through a nasogastric tube by the litre of this lady and all she needs is a hip replacement, but a hip replacement is not likely to be done because it needs beds.

CHAIR - She can have a laparotomy though.

Dr ALEXANDER - Yes, she'll have a laparotomy. The costs of scripts, the cost of visits, I don't know -

CHAIR - She took up a bed for 13 days.

Dr ALEXANDER - Thirteen days, yes.

CHAIR - An HDU bed, where she'll end up with a hip replacement as well, no doubt, or ICU for a few days probably.

Dr ALEXANDER - The reason I use her, I could sit here anecdotally until 5 o'clock today doing this from our surgery alone, but I just think that's a really good example of where we are at, and work in that system and everyone is thinking, 'What on earth am I doing this for?'.

CHAIR - Do you have any communications with GPs around the state? I'm not suggesting that your surgery is unique - but I'm just wondering if you do actually.

Dr ALEXANDER - It's everywhere. You just have to get a group of GPs together and that's what we talk about. It's always that thing, 'What's the point? I should give up and do skin clinics or I should do …' anything.

Dr GOODWIN - Graeme, my question is around the issue of staff morale across the system hitting rock bottom, what are the implications of that? Are people leaving the system or is it only a matter of time before that happens?

Dr ALEXANDER - The worry I have is the future workforce. Yesterday in South Australia a coroner's inquiry found a doctor guilty - an 83-year-old overseas-trained doctor - of killing a patient. He admitted guilt. A workforce study showed for GPs, even if we get the best-case scenario, we will not have enough GPs in a decade's time. Again, it's a dog's breakfast. I talked about it last time. Medical students' internships - if you have family who are in the system you will understand this - first, you are a medical student for five years, you have to be an intern - the bottleneck is still there - then there is a residency, a registrar job and a training program. The government blindly jacks up the number of medical students. I have been saying for 10 years we need more medical students but someone has to plan ahead that in five years' time there are more interns. This state moved quickly to silence the front-page headline to give everyone an internship. Nationally, they haven't. Tanya Plibersek is throwing $80 million at the states, begging them to employ medical students who can't be interns. There are hundreds nationally and each year there are going to be hundreds more.

CHAIR - Employ them as what?

Dr ALEXANDER - They have trained for five years to be a medical student and then they have no job.

CHAIR - So no internship?

Dr ALEXANDER - No internship. Tanya Plibersek wants to give the states money to employ more interns. Our government moved, I would say politically, to fix this problem, but there is a more cynical thing here in that the interns are the cheapest workforce medically in the hospital. From what I hear, and it's reported to me, there are now interns doing residents jobs and residents doing registrars jobs. No-one is being replaced in any of these positions because of cost savings, so you have very unhappy doctors in the hospital. It may be a boost to general practice because I heard the other day for the first time GP training numbers are going up. They are saying, 'I can't work in this place anymore'. Just imagine the training these people are getting in this hospital, when they have to work in this system. Imagine the morale amongst them. Basically they're saying, 'I don't want to do this anymore'. Nursing is exactly the same. Training all that time, no clinical positions. So it is the future workforce I worry about the most.

Dr GOODWIN - We will lose these people to the mainland, won't we, and we won't get them back.

Dr ALEXANDER - Absolutely.

CHAIR - There are the same problems on the mainland.

Dr ALEXANDER - That's the other thing. Originally they were offering fewer internships on the grounds that 'historically many of our medical students have done their internships on the mainland'. Well, that's stopped. The reason it stopped is there are more medical students qualifying in other states so they're going to take up their own graduates.

CHAIR - We've just had the two groups graduate together this year?

Dr ALEXANDER - I think it's already been through. The numbers are going up and up. The medical school is growing very fat on training medical students. It is leadership and policy: what workforce do we need? We increased medical students and five years later we increased internships and then residents and registrars. Why we are training medical students who will never become doctors is mystifying to me.

CHAIR - One of the recommendations in our interim report was about this clinical workforce planning strategy because it's not being done. That is across the medical profession, as well as nursing and allied health.

Dr ALEXANDER - The bean counters are still there. I'm sure you're going to hear lots of things about how many discharge summaries are done and ticked. This would have got a tick as a discharge summary, the one that has two words in it, but to us it's useless.

CHAIR - Are they sent electronically to your office?

Dr ALEXANDER - It is electronic. I think they have improved overall and their numbers have improved but, again, for 2012 it is mind-boggling. As you said earlier about the

communication, isn't it better to get the GP involved - yes it is, but we're not; we are not involved with any of this. We have to scrounge and try to find results and letters.

CHAIR - I was thinking with electronic access to records, when the activity-based funding model starts, everything will need to be recorded because that's on the basis you are funded, as to what happens to who and when and where. Do you think that may have a positive impact, that a discharge summary should include the detail you would expect to get from a patient such as that lady?

Dr ALEXANDER - It should do; there would be a huge cost saving if it was. It should be part of the whole thing.

Ms FORREST - It shouldn't be happening; I absolutely agree with it.

Dr ALEXANDER - As far as reaching benchmarks, I don't know if anyone is as pessimistic as I am for Tasmania about what benchmarks we could -

Ms FORREST - Whether we have benchmarks.

Dr ALEXANDER - Yes. The thing you mentioned earlier about beds; a week ago in our surgery, one of the other doctors asked me about the case of a child who had a massive foreign body. We have this situation where we often don't ring any more. I don't want to hear how busy they are; I don't want to hear my surgery bursting at the seams, and I ring someone to tell me how busy they are. I don't need to know that. However, this doctor in question rang about a child who needed an anaesthetic and sedation to get this. He rang and they said please don't send them here.

Ms FORREST - Are you talking about the Royal?

Dr ALEXANDER - The Royal. Where else do you send them? Please do not send them here. I think the quote at the time was we have 57 in A and E of which 34 are not yet triaged. That was the quote that we got, so we sedated the child overnight and they went to have it done the next morning. That is the level we are working at. It is not just beds; it's not elective surgery; it's across the board.

Ms FORREST - You sedated the child and kept them at the surgery overnight?

Dr ALEXANDER - No, we didn't keep them at the surgery. They weren't in huge pain; it was better that they did that than sit un-triaged in DEM for 12 hours.

It's across the board in every area. The people working in those systems have had enough. It is sad for us. I have offered to send patients to the Health minister's office; I don't know where she's been for the last year, but not very visible. We had Tanya Plibersek wander in with some big PR exercise which, to me, just advertised how much our reform has failed. Where do we go to next?

Ms FORREST - As I understand it, it's $8 million over four years for the whole state for elective surgery. Is that right?

Dr ALEXANDER - I think it was $40 million or something like that. I say again, will the hip lady get done or will they do 10 cataracts or 10 grommets? It is all about numbers and ticking boxes and how it appears. It is not about fixing the problem. I challenge anyone to show me where, either state or federal governments - I can say this because I criticised the Howard government - that's how long I have been bashing my head against a brick wall -the then minister, Kay Patterson and then Tony Abbott, who followed her; I can say this; I challenge anyone to show me where a government minister or representative has stood up and said this needs fixing. It's all about headlines, tweaking numbers and getting past the next election. It gradually - actually, not gradually now - it's in freefall now as it gets worse.

Mr WILKINSON - Graeme, I think I might have asked you the question before and I know some of your answers but I'll ask it again. If you were to become Health minister next week -

Ms FORREST - He thinks, God help me.

Mr WILKINSON - After getting over the shock -

Laughter.

Mr WILKINSON - what would you do?

Dr ALEXANDER - The first thing I would do is show leadership and say that we are going to fix this. It's like most professions across the board; some light at the end of the tunnel would be the first thing. I'd give a 'hang in there, we're going to fix this' type of speech. I would've run up the white flag years ago. I've said it before and I've been saying it for years; we must have one single funder of this system. We cannot have -

Ms FORREST - Cost shifting.

Dr ALEXANDER - Cost shifting. Aged care is the elephant in the room that no-one talks about. Aged care in the state; every now and again they trot out that it's an aging society. We know that. They say it but they do nothing on it. The only time you will ever see an aged care minister is to do a ribbon-cutting ceremony at an aged care facility that is opening up. It's not about the nuts and bolts of funding and running aged care facilities. That's what I would first do.

I would look at the workforce; all sections of the workforce. I would make sure, medically, I'd have a smooth flow through for doctors. I would actually train less if I knew I was going to train them better. Nursing staff; same thing. Allied health; I would make sure we have enough allied health people. I would absolutely ban policies like super clinics, which are, again, just ribbon-cutting ceremony opportunities. It is an opportunity to have a shovel one day, a hard hat and a fluoro vest the next and the ribbon-cutting scissors later on.

I would make sure that in the buildings that I already had I would have people who are working, dealing with patients. Whether they be physios, podiatrists, you name it. Across the board. It would be a workforce-unified system but we need to speak to someone who is interested.

Again, I challenge anyone. In the last 12 months, show me someone who is interested beyond politics. No-one. The opposition: the same. Tony Abbott hasn't mentioned the word since he has been in office. So it's not about politics. It's about healthcare and fixing it.

CHAIR - We are reluctant I think as a community and certainly as a health profession, which I still consider myself to be part of, to have those difficult discussions about how we fix it because how we fix it requires our community to accept that you can't have everything everywhere and you can't do everything for everybody every time.

Dr ALEXANDER - Absolutely.

CHAIR - Who should lead that discussion? This discussion has to be had in my view.

Dr ALEXANDER - It has to be had. First of all, and it has been quoted frequently in the media, health care will consume the whole budget. I don't believe it and it has been taken up and run with by far too many people. If you run health care as a dog's breakfast it will consume the whole budget, no matter how much is in the budget. You look at the one case I have given here today. Like you said, imagine if you just fixed her hip. Imagine the cost-saving. We wouldn't consume the whole budget if we had a decent health policy and health leadership but at the moment it's consuming the budget not from the amount of money, it's consuming the budget because it's the most inefficient system you could ever possibly dream up.

CHAIR - So how do we start this conversation?

Dr ALEXANDER - It has to start from government. It has to start from federal and state governments doing more than sitting around a table with political PR spin exercises. That's all we've seen in health care. Health and hospital reform, I will say it again, the disappointment for me is we are debating. You as Legislative Councillors have had huge issues this year that have taken up a massive amounts of time, massive amounts of media coverage and what we are talking here today is the biggest, but it gets relatively little coverage until you find someone on the front page of the newspaper or on the evening news who has had some catastrophe. As far as hard questioning of our decision makers - zero. Think nationally, Canberra. How often has health care been mentioned in the last five years? Hardly ever.

Dr GOODWIN - Graeme, do you think part of the problem is that it's been so bad for so long that people have sort of become used to it?

Dr ALEXANDER - I think it's become - and I will pick our two leaders.

Dr GOODWIN - Desensitised to it perhaps.

Dr ALEXANDER - Tony Abbott, former health minister, our current Prime Minister, former opposition health spokesman, I reckon they have someone in their ear every day saying, 'Don't mention the word "health"'. You'll be tarnished with it. Do not mention the word 'health' and that's why it's not getting anywhere. The opposition, the Greens - I won't even go there, as far as health care goes and running a health system, all three of them,

nothing. There is nothing coming out. The only reason we had the initial health and hospital reform is Kevin Rudd's popularity was plummeting. That's the only reason we went to it and then the only reason we had the follow-up one is the federal government was in real trouble and needed a deal to sign off on.

CHAIR - It was a watered down thing anyway.

Dr ALEXANDER - Yes, it was watered down and this massive big all sitting across the table and now we've got conflicting Liberal and Labor governments it is so much more difficult. I had a conversation with Kevin Rudd some years ago about this. He should have moved day one when they had all like-thinking governments and maybe we might have got somewhere. I'm not a politician but what I'm getting at is, it's just a mess and the leadership is not coming from anywhere. The discussion has to start from our political leaders.

CHAIR - That should be backed up by the commissions, would you agree?

Dr ALEXANDER - Absolutely. It has to be, and across the board, and it's certainly not just doctors. It's across the board it has to come.

Mr WILKINSON - Has there been any change - I know we are running short of time, Graeme - we spoke last time about the lack of communication between hospitals and GPs. You touched on it at the start.

Dr ALEXANDER - As I said, I'm sure there is this thing that they will tick the box if they had more discharge summaries but I'd love someone to look at the quality and the information and the timeliness. It's one thing to tick a box. There seems to be still a tremendous amount of box-tickers left in the system, but as far as getting genuine change to improve the system, you are struggling.

Mr WILKINSON - If I had an ECG today which was given to me by the hospital, something happened, I went to the GP in a week's time, would the GP have the results of that ECG?

Dr ALEXANDER - If you went privately I would have it in the mail within a few days. I would very unlikely ever receive it from the public system. It would be very unusual to receive it. It would be celebrated in our staff room.

CHAIR - We have run out of time, sorry, Graeme, we have a tight schedule. Thank you very much for making yourself available and taking the time to come in again. I know you get frustrated and I can understand that, we do appreciate your input though.

Dr ALEXANDER - I made the comment if you look at it at least we are looking up here. Thank you.

THE WITNESS WITHDREW.

Mr MATTHEW DALY, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Thanks. You understand the committee process whereby everything you say is on *Hansard* and covered by parliamentary privilege while you are here, but if you say anything outside it may not be. If there is anything in camera you wanted to discuss you can make that request and the committee can consider it.

Thanks for coming back. We are here to get an update. Other members can say what they want to hear particularly about, but we need an update on the savings where they are at, how much has been cut or saved in the last financial year and into this financial year with the $25 million that was required in this year that was the lag from last year, and what impact it is having, and the impacts on services.

Mr DALY - I have focussed my preparation for you this morning to make it as productive as possible around winter, which is what you specified, so I have brought a lot of winter data, some analysis on that data; I have provided the data around elective surgery, but I have put my own cut on it just looking at winter as well, so I can go through that in some detail.

CHAIR - That would be great.

Mr DALY - In relation to the finance generally, you are aware that the THOs finished last financial year with Southern $17 million unfavourable, Northern $400 000 unfavourable which really on that size budget is on budget in my books, and the North-West was $6 million unfavourable, which were dramatic improvements on the previous financial year's performance where they were significantly higher than both those levels. A lot of the financial strategies that they have put in place and reported to the committee and on the website, etcetera, as we know, and it has been talked about at an earlier meeting of the committee that they were strategies that came into place late in the financial year, so there is a big full-year effect and benefit coming into the new financial year. That's not to say that the THOs aren't working very hard to put in additional strategies in order to deliver a balanced budget this financial year. Certainly the main areas where we are still working very closely with the THOs are in the south and the north-west, due to very different reasons.

I think the north has its strategies established and is moving towards that and we are anticipating a balanced budget for the north, but obviously there is still a lot of hard work to do there as well. The southern had the largest dollar figure and they are probably still a little bit above the mark. It's hard to tie that down, but it has come down well below that figure of what they ended with last financial year. The north-west, and I know Gavin is here and no doubt will tell you they are driven by a number of contract issues in terms of contracted services that are very expensive. They are necessary for the community but we're in negotiations and supporting the THO around reviewing the efficacy of those contracts.

CHAIR - That's being going on for a while now, Matthew. Are you not getting anywhere with that?

Mr DALY - Some of the contract arrangements were difficult to terminate.

CHAIR - They had no end date?

Mr DALY - That was in one case. I've never experienced that but -

CHAIR - It is a unique beast.

Dr GOODWIN - You've identified there are some specific areas in the north-west around the contract issues. What's the issue with the south? Why are they struggling?

Mr DALY - A variety of reasons. One is the size of their budget and the dollar task was significant and proportionally larger than the other two. I suspect there is a whole host of historical reasons for that. It's also the tertiary nature of the services there, they are expensive services and services that are difficult to provide in an efficient manner, just because the volume isn't there, and that's why we have had negotiations with the commonwealth and additional funding authority; we are arguing for those to be taken out of activity-based funding. We just can't compete with the volumes of the Royal Melbournes or Royal Prince Alfreds of the world, hence the relative cost of each of those occasions, so they'll probably come out of the activity-based funding. So there is that issue around how we, as a state, support statewide services whether they be out of the north or the south. That's an issue, on advice from the lead clinician group, of 'I think we need some clinical input into this around how we manage and renumerate statewide services'. That's another big component for the Royal in particular as part of the south.

Short suspension.

CHAIR - We were just talking about some of the challenges for the southern THO, or Area Health Service, as it was. Just a couple of things on that, Matthew, to pick up on, you said that the activity-based funding would be a bit of a challenge because some of these services provided by the Royal because it's at tertiary level and the services it provides create efficiency issues. Are we talking about neurosurgery and things like that?

Mr DALY - Yes, we have agreement from the commonwealth already that a host of tertiary level services - cardiothoracic, neonates, neurosurgery - will come out of the ABF funding arrangements.

CHAIR - And they will be block grant funded?

Mr DALY - They will be block-funded. They will be subject to efficient block funding, which means, instead of being compared with the national efficient price for providing with those higher volume centres that I touched on earlier, it will be with other centres of a reasonable size and smaller volume, so it will be appropriately compared instead of compared to a high-volume centre that can generate those efficiencies. Those will be block-funded, but they will be block-funded in an efficient sense and I don't know that that will be done for year one, but this whole national efficient pricing issue is an iterative one with the commonwealth's leading.

CHAIR - Can we look at the impact of the winter issues and how that has impacted this year compared to other years?

Mr DALY - I can cover most areas around the things that we measure. Do you want me to just comment on some of the key indicators that we measure on and I've got the figures winter to winter so we are comparing appropriately. If you want to start with the emergency department, there were some interesting changes in the emergency department presentations. In the south they increased by 1 000 for the relative winter on winter. In the north they dropped by about 1 2000 presentations for this winter just gone compared to the previous winter and in the north-west they dropped by over 2 000 presentations, which I am sure Gavin will talk to you later about. That's a real success story around the use of GP superclinics which could strengthen our argument now that we have evidence around this, with the commonwealth to assist with these types of alternatives to ED presentations. A lot of the presentations are GP-like and now we've got some very clear evidence that if we put in an appropriate GP presence after hours it has a direct impact on our emergency departments.

Dr GOODWIN - Why wouldn't it have had an impact in the south? We do have a GP superclinic here.

Mr DALY - The mix of patients is not skewed to the category 4s and 5s in the other EDs but they still certainly have a fair volume of GP-type presentations. The relative mix in the north-west was that much higher that once we - the commonwealth - put in some after-hours GP services, it had quite a significant impact which is a real -

CHAIR - So are you saying access to GPs has been the issue in the past more in the north and the north-west, whereas access to GPs in the south generally hasn't been as challenging?

Mr DALY - I still think it's an issue. I think the number of GP-type presentations we receive in all our emergency departments are more than what they should be. Certainly in my experience, where there is a better GP presence both in terms of numbers and also length of operating hours, we should be seeing less GP-type presentations.

Dr GOODWIN - Within the emergency department presentations, are they are categorised?

Mr DALY - Yes, 1, 2, 3, 4, 5.

Dr GOODWIN - Do you have the split?

Mr DALY - Yes, I do.

Mr WILKINSON - While that question is being answered, Matthew, - because I was there a month ago I suppose when my wife went there because of a concern - does it include a category of people that probably shouldn't be there in the first place? When I was sitting in that waiting room I saw a few people and I questioned whether they should have been there in the first place. I know it's difficult for me to say.

CHAIR - Being the expert that you are.

Mr WILKINSON - Yes, but I certainly asked that question. Common sense too.

Mr DALY - Yes, and certainly I think for next winter we should be looking at, if this trend continues, some kind of public education campaign around the true use of an emergency department. For those regions, or those parts of the state that don't have access to a GP clinic after hours you probably wouldn't want to leave it if it was your son, child, or whatever.

Mr WILKINSON - I understand that. I'm talking more about older people - the elderly bunch that should know better - and I just question whether they should be there in those emergency departments as opposed to swallowing a bit of concrete, hardening up and going to their doctor the next day. I know it sounds a bit hard but I think you know what I'm talking about.

Mr DALY - I understand. I think there's a potential public education campaign around that.

CHAIR - Just on that as far as access to GPs after hours with GP Assist, what's the take-up of GPs using it, in the south as opposed to the north and north-west?

Mr DALY - I would mislead you if I gave you an answer on that, Ruth. Can I take that on notice and get some advice to you?

CHAIR - That would be helpful to have on the record because greater utilisation of that can lead to DEM avoidance - good use of GP Assist after hours.

Mr DALY - You asked about triage category and we measure now on a national basis the times that we treat these people in the various categories, 1 to 5. I guess if I look at the Royal this winter compared to last winter they actually improved in all five triage categories. The Launceston General maintained all five categories as well. So they are treating more of these patients in the clinically recommended time this winter than they did last winter. The North West Regional Hospital exceeded the performance and maintained that performance across the triage categories, as did the Mersey Hospital. They have consistently been our better performing hospitals against the national targets.

I haven't got the numbers here to answer your question, Mr Wilkinson. If we tied the numbers to those five categories, we'd probably see a higher number of the categories 3, 4 and 5 in the north-west relative to the categories 1 and 2 in the south and the north. I didn't bring the numbers with me.

Dr GOODWIN - Can we request those?

Mr DALY - Sure.

Dr GOODWIN - For categories 3, 4 and 5.

Mr DALY - The numbers against those performances, yes. There are so many ways to cut this pie. I've cut them in certain ways.

Mr WILKINSON - I understand that.

Mr DALY - That was emergency department performance. The other area was elective surgery, that we know has had an impact. The numbers on the waiting list have increased by 223 at the end of this winter, as against the end of last winter. Interestingly, though, if we look at the end of the previous winter, which is well before the budget cuts, the difference is only 35 in terms of the number of people waiting on the list. So, certainly, it had a peak in terms of impact on the waiting list but the waiting lists are dropping on a monthly basis by between one and two hundred, post March. There were initial budget strategies put in place by some of the hospitals for elective surgery, as was well publicised. They had an initial impact. They were readjusting their workload and work practices, which all hospitals need to do. That is now resulting, for the last six months, in the number of people waiting dropping on a month-by-month basis.

CHAIR - I find that interesting for a number of reasons. We hear anecdotally that people are being advised to take out private health cover because you've only got a 12 month wait for a pre-existing condition before you can have surgery, and 12 months is a lot less than five years you might have to wait in the public system for a hip replacement, or whatever. Is that one of the reasons we are seeing a decline in the waiting list?

Mr DALY - Potentially, but I think it's much more complex than that. Patients come off the waiting list, that is, they have their surgery, and patients are almost immediately added to the waiting list. Where big investments have been made in elective surgery over the years, waiting lists don't necessarily drop as you'd expect, because the number of patients coming onto the waiting list increases just as the number coming off increases. It's a really interesting study. There's a PhD there for someone, trying to understand that.

CHAIR - I think it might have been done.

Dr GOODWIN - Is 223 the total, statewide, on the waiting list?

Mr DALY - Statewide, yeah.

Dr GOODWIN - Do you have that broken down into regions, and types of procedures they're waiting for?

Mr DALY - I haven't got them by type of procedure. I've got comparative, for example the Royal Hobart Hospital - comparing this winter to last winter; their numbers on the waiting list have dropped by 312 between last winter and this winter. The Royal figure has increased between last winter and this winter.

Mr WILKINSON - Do you mean Launceston General Hospital?

Mr DALY - Sorry, yes, Launceston General Hospital has increased and the Royal Hobart Hospital has dropped. Although, Launceston is now starting to trend down as well. I have brought some graphs of this if you would like me to leave them with you.

CHAIR - All right.

Mr DALY - It is just graphs of the data I've provided.

CHAIR - Where are your figures up to?

Mr DALY - To September, so that I could report on the winter performance compared to the previous winter performance.

CHAIR - It would be helpful to have that because the information we have here just goes to the end of June. Waiting times are probably more of an issue than the waiting list because it's the length of time people wait that can create other problems and demands on the health service. You weren't here for our previous witness, but a lady in her 70s needed a hip replacement, and required opioids, analgesics and anti-depressants for the severe pain. Because of the prolonged wait, and the opioid use, she ended up in the Royal with a bowel obstruction. She required a laparotomy and ended up in the HDU with renal insufficiency for a period, using a bed for 13 days, and she did not get the hip replacement. She's still waiting for that. If she wasn't still waiting, she may have avoided that admission. So, where are waiting times going?

Mr DALY - Again, there are a couple of different ways you can cut waiting times. If we look at those patients who received their surgery - all patients who are treated - the time they have waited this winter to last winter has dropped by two days. That is across all categories, whereas the waiting time of patients, winter-to-winter, has increased by about 40 days. But that is starting to trend down across the facilities as well.

Mr WILKINSON - Is that at Launceston, or all over?

Mr DALY - Statewide.

Mr WILKINSON - So the Royal has dropped by two days, north and north-west has increased -

Mr DALY - No, that drop of two days is for any patient who receives their surgery. They are now receiving their surgery two days more quickly than they were at the end of last winter.

Mr WILKINSON - I understand you said the overall increase has been 40 days?

Mr DALY - Between the end of last winter and this winter - it's a statewide average.

Dr GOODWIN - Those waiting times presumably vary also by the type of procedure they're waiting for?

Mr DALY - By procedure, by category - yes, they do.

Mr WILKINSON - Are we able to get a snapshot of that? Some would say it's easy to get grommets done and that could cut the waiting lists down by quite a bit because you could throw a few of those people in to get fixed and bring the waiting times down.

CHAIR - I think all orthopaedic surgery - hips and knees - you could do a heap of arthroscopies too and get a few out as well.

Mr DALY - We can cut it that way.

CHAIR - With the information you tabled here, Matthew - the waiting lists - can you provide the north-west data?

Mr DALY - The north-west data is included in our statewide data.

CHAIR - You've got it broken down for the LGH and the Royal, but there's nothing in here for the north-west at all.

Mr DALY - Okay.

CHAIR - It was reported in the media that there was a significant increase in the number of ambulances ramping, as well as a lot of sick leave with the nursing staff, and bed blockages et cetera. The figures don't always tell the whole story. What was the reality over winter?

Mr DALY - The system has performed remarkably well considering the readjustment it had to make with the budget reductions of last year. The rise in elective surgery numbers on the waiting list was to be expected. I think the CEOs, to their credit, are re-engineering the way they do business. Six months of data trending down indicate they're having an impact on numbers on the waiting list. In relation to emergency department performance, from a national perspective we're in the middle of the pack. I've commented already on the fact that the Royal has increased their performance compared to last winter. Launceston have improved upon three out of five categories and the north-west has met all national benchmarks. So they've actually clearly prioritised their investment decisions to those hot areas of a hospital, which are your front door and your emergency department, and are starting to make an impact in relation to elective surgery waits. There will always be, unfortunately, individual cases like the one you've quoted. They are the reasons that CEOs are working with their clinicians to look at changing the way they manage elective surgery within the resources that they've got.

Mr WILKINSON - Matthew, I know that it's extremely difficult and if there was an easy answer it would have come about - and you would probably get frustrated with people like us asking you questions as though we're experts, which we're not. I know in the US they work around-the-clock. I don't know whether they do it all the time but I was speaking with a doctor a couple of days ago - a specialist - and he was saying that in the US, it is 24/7, just to keep clearing.

What would be the added cost, let's say - because we're here at the moment for the Royal - if it had this 24-hour service just to try and make a huge impact?

CHAIR - On elective surgery - there is a 24-hour service there anyway.

Mr WILKINSON - Yes, I know that - in relation to elective surgery.

Mr DALY - It would probably be uneconomic as we move into a national funding environment. It wouldn't be able to be done at the marginal cost; it would be at the full cost plus, which the Commonwealth obviously wouldn't fund their proportion of, and the state doesn't have the capacity to fund their proportion of that cost above the national efficient price. I think what has been done is that we have been able to grow the amount of surgery we're doing at the marginal cost. An example is, instead of running eight-hour

sessions you run 10-hour sessions and in those two hours you are able to perform at the marginal cost. So just little re-engineering exercise like that, clinically driven and supported, can actually deliver and improve volume at that marginal cost. They're the types of exercises the CEOs and the directors of surgery, however named, are entering into.

As I said, with six months of data, they're trending down; I think it's a really positive sign.

Mr WILKINSON - Okay, thanks.

CHAIR - With regard to emergency surgery, have you seen an increase in that? I mean, particularly patients who present as emergencies but who are on the waiting list, if you break it down by that level of detail.

Mr DALY - Yes. Of course emergency surgery is an indicator on how the patients are responding, particularly being delayed. At the end of winter last year, there were 2324 emergency theatre cases and that was before the budget cuts came in. At the end of winter just gone there were 2320, so it was virtually line ball. So there has been no change in the number of emergency surgical cases presenting across all our hospitals. It is fairly consistent; there is no one stand-out. They're all either marginally up or down to give that state-wide result.

CHAIR - Just looking at the overall budget situation, we know in the 2011-12 budget there was the $100 million savings requirement, which wasn't met; it was $25 million short, and that was taken over to this current financial year. You're saying that it was still $17 million short in the south?

Mr DALY - Yes, of that 25, or it was a little bit less than 25 agency-wide, the Royal was short 17; so that was the carry-over, which is a far more sensible way of managing a budget target like this over the two financial years.

CHAIR - It's not just the Royal, it's the southern area health service, wasn't it?

Mr DALY - Yes, it is, sorry.

CHAIR - Yes. When we're talking about the north and north-west as well, they're an area health service incorporating all the little hospitals.

Mr DALY - They are indeed, yes.

CHAIR - So as far as this year goes, the minister, sensibly, made a decision not to impose the proposed cuts this financial year. So as far as meeting the full $100 million, that will be done within this current financial year, and are there other expectations of further savings?

Mr DALY - No, the out years have had the further budget reductions taken out for the next two years. Part of the funding agreement with the commonwealth, you would be aware, is that there is a maintenance of effort condition to that package, so I assume that will be

adjusted in the further out years. No, the current forward estimates for the next financial year is for no other budget reduction.

CHAIR - You would expect all THOs to come in on budget then?

Mr DALY - That is certainly the objective that we are working to and the governing councils who are now working and supporting the CEOs very actively are overseeing the strategies that are required to deliver. As I said, there are some difficulties in the south and we are working with them as with the north west, but for very different reasons. We meet on a monthly basis and performance review with them. That is why I can tell you where the difficulties are, but all the governing councils, having met with them two weeks ago, understand the need to come in on budget and working towards that end.

Mr WILKINSON - Can I ask a political question and you may not be able to answer it because of that, but you have seen the THOs up and running already. Are you able to see any cost savings and, if so, are you able to estimate those cost savings compared to if there was one THO?

Mr DALY - That is certainly a theme that has been coming out of the consultations that the commonwealth commission have been having over the last three days. I am always a little bit puzzled about what the community expects in terms of significant savings coming out of those arrangements. Despite what people might think, I think we are pretty administratively lean and it gets to the point of a diseconomy of scale to under-investment in the support services around the core business.

I have never sat down and calculated what those returns are. I guess I know one of the objectives from the lead clinicians group will be around ensuring a greater complementarity of services as we refresh the Tas Health Plan and work that up. That certainly has been part of the conversations I have had with the members of that group. My initial impression was that there would probably be marginal savings. It's more about sensible and complementary planning of services across the state to each other rather than allowing them to be siloed, but that is certainly one of the objectives clearly in mind of the common chair, Graeme Horton, to manage the three or guide the three governing councils with a statewide as well as a local perspective.

Mr WILKINSON - I say that because with your water authorities, as you know, some argued that in the first place there had to be three. Now they have realised there was a saving of between $5 million and $8 million, I think the figures were, with just the one. I would have thought - and this is my uneducated view - that history would say there would be a saving. It would all depend upon how significant that was in relation to whether that path should be trodden, as opposed to leaving it as it is.

Mr DALY - I guess that is a debate for government and legislators to consider about the benefits of those marginal savings vis-a-vis the local engagement and local ownership. The success we have had recently on the north-west and the role of the Mersey was a win for common sense, but it was as win that was locally led and supported by many - though not all - parts of the community. I know, not because I was here, but having looked back we have clearly tried to introduce some more common sense planning and a greater complementary role for those two hospitals, which in my opinion are both needed in the north west. But we are now moving them towards a more complementary role and it was

really pleasing see the commonwealth support us because it really was the right thing for patients.

CHAIR - A couple of things there Matthew, you said about refreshing the Tas Health Plan, which had significant benefits for the north-west and is a more inclusive and comprehensive service across the region as opposed to silos, which is still a bit of a challenge. Where is that at? Some of that you might want to answer or Gavin might later, perhaps, in relation to the contractual issues that create problems for budget management in the north-west?

Mr DALY - I might let Gavin comment on that because it is his budget and his hospital and he's very close to it. The lead clinicians group was announced this week by the minister, as you know, and I have met already with the chair, Alasdair MacDonald. We are planning the first meeting of that group before Christmas.

Dr GOODWIN - Does that have any costs associated with it?

Mr DALY - No. The majority of people are already employed by the public sector. There may be one clinician who will be giving up private practice time, who we will pay at an already established rate. It is being supported secretarially by the department - by the planning people - so there will be no additional cost other than a cup of tea for them when they meet.

Dr GOODWIN - And whatever that other person costs.

Mr DALY - We are talking about a very small sum of money there.

CHAIR - Is there backfill for some of the staff?

Mr DALY - No, unless the CEOs take a decision, and I would be surprised if they do. A lot of this work will be done out of hours because it is generally easier for clinicians to meet then anyway, so the impact on where they work should be minimal.

CHAIR - So it is entirely voluntary?

Mr DALY - Yes.

CHAIR - With the rescue package, and the maintenance of effort which is a requirement of that, can you tell us about the real impact on elective surgery? There is the component that is tagged elective surgery - what does that mean and how will it apply?

Mr DALY - We've negotiated that $9 million, and that will fund a total of approximately 1 400 additional procedures this year. They are targeted at those patients waiting longest within their clinically-recommended specialty.

CHAIR - So it's across all specialties?

Mr DALY - It's across those specialties for those patients waiting the longest. It's addressing patients such as the lady you mentioned earlier, to avoid that exact circumstance.

CHAIR - So it's $9 million over this financial year?

Mr DALY - Yes, and there will be a similar amount next year. We will review the waiting lists with the hospitals and the commonwealth, which has a say in this, to look where their long waits are and continue to target that additional elective surgery

Dr GOODWIN - So it's $9 million this financial year and $9 million next financial year?

Mr DALY - Yes, it is $32 million all up but it fluctuates a million here and there between each year.

CHAIR - Will this be spread fairly evenly across the state - $3 million each, say?

Mr DALY - The exact figure is $9.2 million this year and it is funding 715 additional procedures.

CHAIR - This year?

Mr DALY - Yes, this year. It is only for this year. We have to renegotiate it with the commonwealth each year. It is 715 procedures this year - 362 additional procedures in the north, 288 in the south and 65 additional procedures in the north-west, targeted at long-wait patients.

CHAIR - That would indicate there are many more long-wait patients in the north?

Mr DALY - The dollars were fairly evenly distributed, but some patients who were waiting longer were cheaper than others, and some were more expensive. So the dollars were fairly proportionally distributed, but the number of patients, depending on the cost of their procedures, did vary, hence that difference between north and south.

Dr GOODWIN - Are able to give us some up-to-date information on the staffing changes, and are more staffing changes anticipated?

Mr DALY - For those hospitals which haven't locked down their on-budget performance, I suspect there will still have to be some FTE changes, whether they are reductions or movements into different areas to prioritise the hospital's activity. Yes, I think there probably will be, but certainly not to the tune that we saw last year because there is a big full-year effect from the hard decisions that the CEOs took last year that will flow on, just by maintaining those decisions.

Dr GOODWIN - So I need to ask the CEOs individually about that?

Mr DALY - About what type of FTE reduction?

Dr GOODWIN - Yes.

Mr DALY - Yes, they would be the best ones to advise on that.

CHAIR - Have you finished?

Dr GOODWIN - I also asked about the most up-to-date figures that you can get.

Mr DALY - Sorry, in what way you would like me to answer that? Just in terms of their FTE numbers?

Dr GOODWIN - The FTE numbers, yes, and if you've got a break up of the type of staff as well. Anything you can provide will be useful.

Mr DALY - We could talk about some figures at the end of June 2010, or the end of -

Dr GOODWIN - Is there anything more up to date than that?

Mr DALY - I can give you gross numbers, but comparative figures might be a bit more helpful. We can look at contemporary figures, and take the southern as an example - in June this year they had a total of 3342 FTE. At the end of September - the end of winter - it was 3223, and that would be reflecting the full-year effect of last year's strategies with the FTE reductions flowing into the new year.

The north-west at the end of June 2012 - 1234. At the end of September - 1251, so that would reflect flexing activity up to manage winter, I would suspect. The northern is pretty much line ball - 2117 against 2121. So they are fairly contemporary figures, before and after winter.

Dr GOODWIN - So you don't have a breakdown of what type of staff they are - doctors or nurses?

Mr DALY - Yes, would you like similar comparisons for the three?

Dr GOODWIN - Yes.

Mr DALY - Nursing southern - 1252 compared to 1234. So what other categories would be useful other than nursing?

Dr GOODWIN - The corporate, admin, medical, doctors.

Mr DALY - Maybe I can give you allied health and medical. Allied health: 393 vis-a-vis 389.

CHAIR - This is for the south?

Mr DALY - Yes, for the south; salaried medical practitioners: 371 versus 378. For the north-west, nursing: 542 versus 544; allied health: 90 versus 91, and salaried medical practitioners - this is a very good result given medical staffing issues in the north west - 102 vis- a-vis 111. For the north: 894 vis- a-vis 889; for nursing, allied health: 182 versus 186 and medical practitioners: 194 versus 190. So there are some contemporary examples of staffing numbers.

Dr GOODWIN - Any data on administrative staff changes?

CHAIR - Non-clinical perhaps.

Mr DALY - The kind of award structures are a little bit confusing. It is not as cut-and-dried. There is not just an admin and clerical award in the Health and Human Services Award. I can give maybe a gross figure, but that would be include staff that would be deemed to be actively part of the clinical team.

Dr GOODWIN - I think you struggled with this previously.

CHAIR - Including frontline staff.

Mr DALY - It is not just broken up for cleaning, catering and maintenance. I could throw some figures at you.

CHAIR - You gave us the overall staff, didn't you? So you can extrapolate that out. Overall, it seems to me that there have been some staff movements, but not huge in the directly clinically-focused areas like nursing, medical practitioners and allied health. There has been an increase in the north-west in your medical staff there. Are they mostly at the Mersey?

Mr DALY - I suspect across the Mersey and the north-west, but Gavin would probably be best to give you the detail of that. There is no doubt that all of us, whether it be at the departmental level or a THO - previously Area Health Service level - prioritise the budget cuts to non-direct patient care areas.

CHAIR - How many staff have you lost from within your department, within the DHHS that are not hospital-based employees? That is what you want, isn't it?

Dr GOODWIN - Yes.

Mr DALY - The minister set me a target of reducing by 150 FTEs within the department and these reduction figures have actually rolled over into this financial year as well. So there have been some continued FT reductions and across the department that now reduced by 181 FTEs.

CHAIR - So you have virtually done more?

Mr DALY - Yes.

CHAIR - Are you able to table the list of positions that you have lost or shed?

Mr DALY - I can provide it by the various business units of the department. I can provide that. This has all my scribbles and everything on it, but I can get you a clean copy of this. It just shows the 181.

CHAIR - It identifies the areas within the department that these positions have been shed from.

Mr DALY - Yes, that is right and it has excluded areas like direct service provision and Children and Youth Services, also for Housing and Mental Health. So it was around what you would deem as the corporate support for those services - you know, policy

development. There are dangers in this as well to think that these 181 have been sitting drinking coffee is dangerous, particularly given issues around policy development, quality assurance, commonwealth-state negotiations and our capacity to influence the commonwealth and maximise the commonwealth dollar into the state. I have been very cautious around how I have allowed deputy secretaries and service directors or chief executives to cut. The easiest thing to do is just to cut without being conscious of the short to medium term impact that could have on us and our state in terms of securing commonwealth dollars. We should have big commonwealth dollar programs and we are competing against the other states for that money. We have a unique situation in Tasmania which we are selling really well, but we have got to back it up with good program proposals to secure those dollars.

CHAIR - Do you think the cuts have compromised any of that? Any positions that you have shed.

Mr DALY - In my department?

CHAIR - Yes.

Mr DALY - I would like to think not, but I guess responding even today that you have appropriately been a little bit critical of the timeliness of it, and what we have been able to find. Hence I have always come back to you when we have identified other things. Our responses to questions-on-notice, RTIs, all of which are climbing and our capacity to respond in a timely is really difficult.

Dr GOODWIN - That means your existing staff are doing more?

Mr DALY - Most certainly; of course, they are, yes.

CHAIR - Is it your opinion, Matthew, that the cuts have not compromised your department's ability to argue the case with the commonwealth. That is the big point you are making here - that if we want to get consideration of own uniqueness and challenges that Tasmania face which we all know about, has that been compromised?

Mr DALY - There is no evidence of it being compromised to date and given that that is now a greater role of the department. Now that we are out of actual direct service delivery, then our job is to maximise the commonwealth and every other dollar into the state for our system, for me to deliver to the THOs. I am very conscious that I cannot let that be compromised because it will hurt us far more than what an FTE dollar may deliver to the state.

CHAIR - I did ask you about this when you mentioned questioning the Tasmanian health plan - where are we at with that? What is happening?

Mr DALY - I have agreed on an initial process with the Chair, Alastair McDonald, to bring forward either current-contemporary plans for review rather than reinvent the wheel. As this is going to be a clinicians' plan, I think it is really important that they have ownership around describing how they want to approach it. So the first meeting will be getting buy-in from that 14-member lead clinician group and their advice around how they think it is best being pulled together, how we are best consulting with other

clinicians right across the state to ensure there is statewide ownership of it. We are at that point where, hopefully before Christmas, we will have had that meeting and that we can do the toiling because data has to support all the decisions that are going to be made around enhancing the plan. There is a lot of work in terms of demographics and bringing that forward to inform this group so that they can pull a plan together to give advice.

CHAIR - So you are not reinventing the wheel. You would have read our report I am sure. Even though the minister may need to put comment on it, but I am sure you have read it. One of our recommendations was around really revisiting the health plan and trying to establish a clear strategy for health in the state, which is one of the criticisms that we are a bit rudderless.

Mr DALY - Certainly, what we will be bringing forward are the current health plans we have. We have a renal services plan. We have a cancer plan because we are working towards it as example on the north-west. Similarly we have also got other major planning exercises that are still relevant today. Certainly with the way health changes some of it would have changed but we have the health plan from Dr Wellington and her input and the Richardson plan. So all of these are coming forward to the lead clinicians' group so we can extract any still-contemporary planning issues that are within those documents and then pull it together to mould it.

CHAIR - What I am hearing you say then that there is a squillion of them you can suggest - important plans and documents. Many have sat on shelves for a very long time. Many of them said the same things predominantly as well. So the lead clinicians' group are looking at this, under Alastair McDonald, to come up with an overarching plan for the state.

Mr DALY - Yes, it is. I used the term earlier I think, 'a refresh of the Tas health plan' because that plan expired.

CHAIR - The Wellington report.

Mr DALY - Yes, Heather Wellington had a big hand in it. That plan expired in 2012 so it's most opportune that we pick it up on its expiration date for another three- to five-year plan. My advice to the group was that health changes so quickly that a five year plan becomes meaningless in the last couple of years, and trying to plan anything further out than three years in health -

CHAIR - That health plan was put back on the shelf when John Howard intervened at the Mersey Hospital. That's the reality. You were here at the time. I am interested in the fact that you are saying it has now run out, and so you are re-looking at it. It was never really implemented. It was never really looked at, beyond the report sitting on the shelf.

Mr DALY - Well, I think that supports the need to bring it forward and revisit it, to make sure the recommendations in there are still contemporary.

CHAIR - What time frame have you got? When do you think we are going to have a document, and a clear strategy for where we are heading in Tasmania? How are we going to deliver health services - when, where, who to, at what level and all those things?

Mr DALY - I have done three of these major planning exercises in the past and the timeline to deliver them has been between six and 12 months. Six months was where I entered a distressed organisation where there was truly a burning platform and delivery was required in six months. Twelve months was when it was more of a steady state. I think we are somewhere in between those. I don't think we are on a burning platform, and some of the figures I've shared with you this morning on our performance within the state, and nationally, reinforce that we are not on a burning platform. I envisage that we should be able to develop this in approximately nine months. I know I am going to be held to that forever more.

CHAIR - Correct. That's why it's on the record.

Laughter.

Mr DALY - I hope that nine months is a reasonable period for clinicians to look at this, engage with their colleagues and make recommendations to the minister for taking this forward.

CHAIR - I question whether the clinicians will be brave enough to make non-politically popular recommendations, because that is what it is going to take.

Mr DALY - Again, clinicians are the same in Tasmania as in Victoria and everywhere else.

CHAIR - They want the best for their patients.

Mr DALY - Absolutely, of course they do. I have had conversations with these types of groups, developing plans, in the past, and we work in an environment where we're responsive and responsible to the community, ultimately, through the government. To put forward recommendations that are not acceptable to communities and hence not acceptable to government, can, in the extreme, undermine all the good work within a plan.

Ms FORREST - I'm not talking about extreme. I'm talking about a realistic, practical way forward that provides a sustainable health service.

Mr DALY - My advice to this group, as it has been to others, is that regular usage of the c-word - 'close' - strikes fear into the hearts of our communities and can subsequently impact on the capacity of government to support the plan generally. You gave some evidence about how the federal intervention in the Mersey Hospital hamstrung the plan, and clinicians' commitment to the plan. I will be trying to guide them in such a way that we do the best for patients across the state. But, life is a compromise, and I will be seeking their support to deliver something that is acceptable to community and government so that we can progress it, rather than having a situation of the whole plan being unacceptable because of one or two recommendations in it.

CHAIR - Thanks. We have run out of time.

Mr DALY - I talked too much, sorry.

CHAIR - No, that's all right. It's always good to get some of that on the record. Thanks for your time again. There are a few things that Lisa will contact you about providing. We appreciate your time. We will report in due course and hope the minister might respond to that next report.

THE WITNESS WITHDREW.

Ms JANE HOLDEN, ACTING CHIEF EXECUTIVE OFFICER OF TASMANIAN HEALTH ORGANISATION SOUTH WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Hi Jane, it's Ruth Forrest, how are you going?

Ms HOLDEN - I'm good thanks, how are you?

CHAIR - Good. Are you ready to have a chat?

Ms HOLDEN - Yes, I am.

CHAIR - We've got the meeting here, as you would probably be aware, with Jim Wilkinson, Vanessa Goodwin and myself.

Just so you know, it is being recorded on *Hansard* and everything you say now is covered by parliamentary privilege, but may not be if you repeat anything outside the committee. And if there is anything you want to say in camera you need to make that request and the committee could consider it.

So, thanks for making yourself available. You're not driving, are you?

Ms HOLDEN - No, no, I'm not. I just wanted to open by giving my apologies for not being there in person. I had a commitment - I'm in the north-west, as it happens. So, I apologise for not being there in person.

CHAIR - That's all right. I will turn the volume up a little bit. We're after a bit of an update following the report, which contained pre-winter data, because we were quite concerned by the evidence of a number of previous witnesses about the impact of winter. Things were bad enough before winter, but with the usual challenges of winter - sickness of staff, as well as increased medical conditions for patients - we want you to give an update on how it has been at the southern THO, and perhaps also talk about issues of staff numbers and staff morale. Would you like to give us a bit of a general update, and we will get into questions after that?

Ms HOLDEN - Certainly. It has been a difficult winter for the staff. We've seen a four per cent increase in the number of patients admitted to our emergency departments. In July it was particularly notable that we had a 17.8 per cent increase in the number of patients admitted to the emergency department, compared to July 2011, but in fact a 19 per cent increase compared to the previous month of June 2012. That translated to about a four and a half per cent increase across the first quarter in terms of weighted simulation. That's when we add the complexity of the admissions that we see and it would have been about 630 weighted simulations of would have been a higher number of - about the same in terms of raw admissions, in addition to the previous quarter.

CHAIR - So, you're saying there wasn't a huge difference in numbers, but their complexity was greater.

Ms HOLDEN - No, there was both. Their complexity was greater and there were 630 more admitted.

CHAIR - One of the concerns that has been discussed is the fact that people on waiting lists are more likely to present at DEM, and even for admission for a range of other problems, because they are waiting for their surgery, or because of the impact of the medication they may be on to manage their pain, or whatever it is. What that a factor that contributed to those increased numbers?

Ms HOLDEN - No, it was largely the acute or chronic patients that we were seeing. So, while we saw some significant trauma during that period on behalf of the state, most of the patients we were seeing were either patients presenting with flu-like symptoms or chronic disease patients with acute exacerbation.

CHAIR - Not on waiting lists and not as a result of awaiting surgery?

Ms HOLDEN - No. The *inaudible* the south has done quite considerable work in terms of managing the waiting list. Although the complexity of patients we have been treating in the elective areas is slightly down, the volumes we have maintained by and large against last year.

CHAIR - So you're saying the elective surgery didn't see a huge reduction?

Ms HOLDEN - No, we managed to be slightly under. I can't give you that exact number but it is not an enormous amount. I think the number is around 60.

CHAIR - Is that across the range of elective surgery areas?

Ms HOLDEN - Yes, it is.

CHAIR - As far as the reduction in nursing staff and other staff numbers go, what sort of impact has that been having so far as staffing during the winter? It was reported in the media at one stage - I don't know whether it was at the Royal; it might have been at the LGH - that one of the reasons they couldn't reopen beds or even staff beds was staff illness. When you cut staff and have less available your option to cover them is reduced. Is that an issue for the Royal as well?

Ms HOLDEN - Yes, it definitely was an issue for the Royal. I think it was published as well. When the community gets these significant flu episodes so do our staff because we are a small cohort of the greater community, so that definitely affected us. We needed to use more of our casual staff and we saw an increase in double shifts during July and August this year, although that settled right back down again in September. During July I needed to have additional beds opened. There were 28 beds opened during July, which was not every day, but across the whole month. In August I opened an additional five, in September I *inaudible*.

CHAIR - What impact has that had on your budget, particularly the extra double shifts and the reopening of beds?

Ms HOLDEN - We were expecting a slight *inaudible* in winter this year; just because of the cyclical nature of these things we anticipated we would have that and we had budgeted for double shifts during the winter and the need to maximise the staff on our casual pool. Our budget is running fairly well. We have been able to hold our expenditure against what we forecast our budget would be, although we remain slightly over the budget we are looking to achieve.

CHAIR - We had the Secretary of Health here previously, Mr Daly, who indicated the southern THO was $17 million over budget and said there was a range of challenges as to why that is the case. How are you managing that? Are you likely to meet your budget this year?

Ms HOLDEN - I *inaudible***]** the latest figures that was a previous report. We are looking now at $40.2 million over budget. It is worth noting we are absorbing some additional costs that we funded at level 4 of $0.7 million. We continue to have some saving strategies that are largely based around a continued focus on proving our business procurement processes as well as continuing to roll out an electronic rostering tool, ProAct, throughout the whole of the organisation, which is certainly allowing us to make sure we have a better match between staff rostered and staff required on any one shift on any one day.

Mr WILKINSON - Can I ask you, Jane, how many beds on average are in use each day at the Royal Hobart Hospital?

Ms HOLDEN - You can.

Mr WILKINSON - 'Can you answer?' is probably the better question.

Ms HOLDEN - I might just take that on notice if I can. I do not have an average here in front of me, but I can probably try to bring that up as we speak.

Mr WILKINSON - Okay, thank you. Whilst that is occurring, when you say that you had to at one stage reopen 28 beds, and of course it is all budgetary, but what is the capacity of the hospital in relation to extra beds - can there be an extra 50 beds, 100 beds?

Ms HOLDEN - Okay. I will just have a look on another file for that, which I have lost.

Mr WILKINSON - Can I ask you a third question while you are looking? The Wellington development - has that had any impact, and if so, what is that impact?

Ms HOLDEN - No, the Wellington Centre is an outpatient facility; it only sees ambulatory patients, there are no inpatient beds there and that will sort of impact on how we manage our outpatient waiting list into the future.

Mr WILKINSON - That would seem to me to be of assistance, especially with your department of emergency medicine, would it not?

Ms HOLDEN - Not really in that these are planned outpatient activities. The emergency department is unplanned.

Mr WILKINSON - Is there any ability within the emergency department to immediately transfer those patients to the Wellington development?

Ms HOLDEN - It is not common that we would see an emergency patient and then transfer them to an outpatient area on the same day because that would indicate that were not an emergency at all and they would go on a similar waiting list. Generally, what usually happens is that from emergency patients are sent home or patients are admitted.

Mr WILKINSON - What I was getting to at the end was: what is the average number of patients who attend the emergency department and are patients that need emergency treatment as opposed to saying 'Look, here is a Panadol, go home.'?

Ms HOLDEN - I wouldn't like to say that the result would be 'Here is a Panadol, go home', because sometimes clinicians have a lot more complex treatment plans than that, but on average, of the 100 per cent of our patients who present to the emergency department 40 per cent are admitted, 60 per cent are referred home, they might be referred to other agencies as well in that as they are within the hospital.

Mr WILKINSON - Okay, so 60 per cent.

Ms HOLDEN - During July we saw that change by about 7 per cent when we needed to admit more patients because of the flu season.

Mr WILKINSON - Would an education program assist with that flow of people into emergency medicine?

Ms HOLDEN - It is something that we do at least annually, remind patients about the role of the emergency department, so yes I think it does assist. If we find patients coming to us that really should be seeing their general practitioner because they are going to get a much better continuity of care, and we aren't GPs in hospitals of course, our guys are specialists, then we do talk to those patients about not coming back and seeking other options in the community for their care.

Mr WILKINSON - Thank you.

Ms HOLDEN - I can just tell you that the total beds on campus are 559 and we are running at about a 95 per cent occupancy and the capacity is 410.

Mr WILKINSON - So, you were saying 559?

Ms HOLDEN - They are the beds that we currently use, yes.

Mr WILKINSON - Beds currently used.

Ms HOLDEN - Between 95 and 98, and sometimes 100 per cent occupancy.

Mr WILKINSON - Thank you.

Dr GOODWIN - Jane, are you able to provide information on elective surgery cancellations year to date?

Ms HOLDEN - Yes. In the first quarter - July, August and September - we cancelled 59 elective procedures, of these 51 elective procedures due to the unavailability. That's the only data I have right now. Of the 59, 37 were cancelled in July and I have spoken to you about that *inaudible*.. That was because there were no beds.

In August we cancelled 20. Three of those were cancelled because there were no appropriate beds, which might mean that we had beds but they weren't the ones we needed. Sixteen cancellations were because there were no beds and one was because there was no ICU bed.

In September we cancelled two. In both instances, that was because we didn't have the appropriate bed. So, we had beds but they weren't appropriate.

That totals 59 we cancelled of theatre bed availability in the first quarter.

Dr GOODWIN - Are there other reasons that procedures are cancelled?

Ms HOLDEN - There are two; the most common other reason is that the patient is no longer fit for surgery so someone might come in and we find that they have the flu or we find that they -

CHAIR - Had breakfast.

Ms HOLDEN - Not often but sometimes, yes. There will usually be a medical reason. The other reason might be that the theatre on schedule has overrun them because of an emergency presentation, or the theatre itself is overrun because it's run late for some reason, but that is less common.

Dr GOODWIN - So there would be a total elective surgery cancellation figure over and above the 59?

Ms HOLDEN - I haven't got that; I've only got the big cancellation numbers I talked about.

CHAIR - The other ones happen all the time, don't they? They're not subject to the cuts.

Ms HOLDEN - We can't guarantee that everyone we believe is ready for care and were ready for care last time we saw them actually are ready for care on the day of surgery.

Dr GOODWIN - Jane, do you have any figures for cancellations for the full calendar year of 2012?

Ms HOLDEN - No. Sorry, I read the brief and I thought you would be looking at availability so I just looked at these ones because that's the only reason that we cancelled them. I will get that information for you, though.

Dr GOODWIN - Thank you.

CHAIR - Jane, on the fact that you still have a bit of a shortfall to make up in the savings requirements, what other strategies - you sort of went to that but didn't really complete

that area, Jane. Can you tell us the things you are planning to do to achieve those savings?

Ms HOLDEN - Yes. One of the things we are doing is forming major programs to maximise revenue. Clearly revenue is a strategy we very much want to make sure we capture, obviously because it's not a saving and it can go to the bottom line. We want to ensure we maximise some more revenue.

The other thing we are looking to do is moving our junior doctors back to manual time sheets. They have been on autopay. We want the new one - the internet model - we think there are a few savings there, as well as rolling out a rostering tool called ProAct right across all of our organisation to make sure that all of the rosters are filling up with the right number of staff in the right place on the right duty on the right day.

CHAIR - So that assists by reducing the need for staff to be called in and double shifts and that sort of thing.

Ms HOLDEN - Correct. It is a projective tool as well so we can look at what we are likely to need and plan that much more easily. At times when we do not need as many staff we let them have their annual leave or not use the pool. What we have now is a much better system. Before, a ward or a department just called in additional staff from the casual pool. We now have a process where they check all other wards or departments - it could be an orderly department or it could be a ward of nurses checking with another ward of nurses or with the whole orderly team - whether or not there is a part of the hospital that has more staff than they need on that day so that we use all the resources we have on one day evenly across the hospital before we then go to the casual pool and call on. This tool allows us to manage that far more effectively than multiple phone calls and everyone getting frustrated. It is just that everyone can see it on the system.

Mr WILKINSON - In the nursing area, Jane, are you able to say what the percentage is, say, of full-time nurses as opposed to -

CHAIR - Can we come back to that? I just want to go back to the savings strategies for nurses.

Can you give us those savings strategies, Jane, so we can get all those down first?

Ms HOLDEN - We are going back to reviewing our procurement processes where through an internal audit we have identified some areas that we can focus on. Reducing the number of consumables that are on our shelves is one thing that we are in the process of doing, as well as standardising what those consumables are. So whilst we do have a *inaudible* [entry] system, we are looking to standardise that right across the organisation and we have put in a tender for an inventory tracking system which will greatly improve our efficiency in control of our consumables, particularly on the floor and we have a better system now for recovering revenue from all of our prosthetics as well.

CHAIR - When you say recovering revenue from prosthetics, what do you mean?

Ms HOLDEN - These would be admissible patients that we are treating and that we haven't been as robust as we could be in terms of maximising the revenue from the prosthetics.

This is particularly around the areas of interventional radiology and the angiography suite.

CHAIR - Are there any other measures you are taking?

Ms HOLDEN - There is a general focus around managing annual leave and all other leave. We have new policies around making sure that leave is planned in advance. Because most of our money is spent on people, these are the areas we are having a very good look at, as well as making sure that we have all our contracts aligned across the organisation, across all disciplines. So there is a major body of work going on there as well.

Mr WILKINSON - I was looking at it in relation to the costs, Jane, a short time ago, in relation to your permanent staff as opposed to the non-permanents.

CHAIR - Casual?

Mr WILKINSON - Are non-permanent staff classed as casual?

Ms HOLDEN - Yes, they are.

Mr WILKINSON - So people can be casual and work on a full- time basis.

Ms HOLDEN - Sorry, there are non-permanent staff who may have a fixed-term contract. So that would be staff that, for instance, we have brought in for 12 months to cover maternity leave or someone has taken leave without pay or because someone has taken a secondment to another position. So those would be fixed-term staff - they are not permanent, they are fixed term. Casual staff are staff who are available to us on - if you like - their terms. We can call them in and we have no obligation to give them any number of hours, unlike the fixed termers, where we do have that commitment. We can ask them to work when we need them.

Mr WILKINSON - Right. That is what I was trying to understand. There are three categories - the permanent, the fixed term and the casual.

Ms HOLDEN - Correct.

Mr WILKINSON - Right, okay. In relation to holiday pay and maternity leave et cetera, the people who would be covered for that are only the permanent staff, and not the fixed termers or the casual?

Ms HOLDEN - No, well, the fixed-term staff would be used to cover extended long service leave or a sabbatical.

Mr WILKINSON - Yes, I understand that, but those people who are on fixed-term contracts - there is no need to pay them maternity leave? If they have a baby whilst they are fixed termers, do you pay them maternity leave, et cetera?

Ms HOLDEN - It would depend. They are our employees while they are on the fixed term and they are entitled to the entitlement of our employees, so they would have exactly

those entitlements. But if their contract ends and they are pregnant, no, we won't have an ongoing obligation to them for maternity leave.

Mr WILKINSON - Okay.

Ms HOLDEN - And, casual staff get a rolled-up rate, in effect. They get paid a higher hourly rate so they're paid their annual leave as they work.

Mr WILKINSON - Okay, thank you.

Dr GOODWIN - Jane, could I ask about the impact of the budget cuts on specialists at the Royal and whether any specialists have been lost to the hospital, either completely or in terms of reduced hours.

Ms HOLDEN - No, none of the staff specialists have lost their jobs. There has been a slight reduction in VMO hours. I can give you some comparisons of the numbers of staff paid, as FTEs, this quarter compared to last quarter. So, clerical/admin - would you like that?

Dr GOODWIN - Yes.

Ms HOLDEN - If I start from the top, clerical/admin and apprentices - last year they were 682, this year 668; radiation therapists - last year 18, this year 17; computer systems offices - last year two, this year one; central offices award - last year 26, this year 26; health professionals - last year 412, this year 391; health services award - last year 576, this year 569; medical practitioners award - last year 394, this year 372; nurses award - last year 1348, this year 1233; senior executives - last year four, this year six; and VMO agreements - last year 18, this year 17. Now, I just want to go back to two issues. First, the senior executives - we are taking on the dental services this year that we didn't have last year. We took on two executives because we took over the oral health services of Tasmania. There hasn't been a growth in those numbers - we've taken on that new service and those positions came with that. So those are the numbers.

Dr GOODWIN - Could I just go back to the specialists - have any of them resigned or voluntarily reduced their hours?

Ms HOLDEN - No, we didn't have anyone voluntarily reduce their hours, and no-one resigned as a direct result of the changes, that I'm aware of. The visiting medical officers, who aren't our staff specialists, we did ask them to reduce their hours and they have, and in some areas we are looking to see how we can try and increase them again and stay in budget to get a better system of service. No one has resigned that I am aware of and any vacancy we are looking to recruit or we are working through how we are going to fill those vacancies.

Dr GOODWIN - Are you saying that no specialists have resigned full stop, or no specialists have resigned as a result of the budget cuts because there is a difference.

Ms HOLDEN - I do not think anyone has resigned because of the budget cuts and your second question is have any specialists resigned in the last 12 months?

Dr GOODWIN - Yes.

Ms HOLDEN - They will have and that will be because they may have another job in another state or it could be any number of reasons and I do not have that number with me here, but I can get that.

Dr GOODWIN - Okay.

Ms HOLDEN - What would you like to know? The number of specialists who have resigned?

Dr GOODWIN - The reason, and their specialty would be useful.

CHAIR - At this stage it would be helpful to know have those people been replaced?

Ms HOLDEN - Yes, they have.

CHAIR - They have all been replaced?

Ms HOLDEN - We have not made any budget savings by non-replacement of staff. That hasn't been our strategy with senior medical staff. I can tell you that, for instance, Clinical Professor Tony Bell retired in August, although he had been not working with us since about March. I had a locum in his position and I recruited to that in September.

CHAIR - Jane, there has been some comment that the staff morale is particularly bad everywhere, not just at the Royal but everywhere across the whole health system including probably out in GP land a bit as well. What comment would you like to make on that in regards to the Royal?

Ms HOLDEN - Last year was tough, but I have been incredibly impressed in working with my colleagues and the whole of the southern Tasmanian health organisation to focus on making sure we get the biggest percentage of every health dollar we get out to our patients. I think there has been a strong commitment to that and I would not think that I would describe morale as bad. I would describe it as pretty stable. People are committed to their job in this role as public servants, delivering health services, and there are probably areas where some aren't so happy, but I think there are other areas where they are very buoyant.

CHAIR - Jane, as far as the cuts [are concerned], and as we identified in our report I would suggest that it has been pretty hard pretty fast, and you identified yourself it was a tough time, do you see now that there is a period where you can stabilise and hope to look at ways to increase access to services, particularly elective surgery, in the next 12 months within your budget constraints.

Ms HOLDEN - Yes, we have developed our corporate plan, it is called Flagship, and the first thing that the F stands for is financial strength and that is not because we think we are going to get a whole lot of money, but because we want to make sure that the resources that we do have are sustainable and stable and used very well. We have been able to, despite making savings, have a relatively limited impact on the services we have delivered. We have coped incredibly well with a 4 per cent increase in the number of

patients and [inaudible] we have admitted 4.5 per cent, and we are delivering the elective surgery that we have been asked to deliver.

There is no doubt that with some additional funding through the commonwealth program we will get some more. We need a little more money to eliminate the waiting list, but we are getting our systems of full utilisation, management of our waiting lists, our admissions quotas are already becoming increasingly more efficient and that should support more patients accessing surgery when they need it. That is one of our goals, that patients access surgery when they need it and not when we can get them in.

CHAIR - Matthew Daly told us that as a result of the rescue package there is a bit over $9 million per annum for the next two years towards elective surgery. He said that in the south there would be 288 procedures as a result of that for this coming year. Do you agree with that?

Ms HOLDEN - Not from the capped funding, no. I'm not sure where he got that figure from.

CHAIR - From your perspective, Jane, so far as the rescue package money - or whatever you want to call it -

Ms HOLDEN - That might be the right figure. I haven't actually got it in front of me, to be honest. At the moment we've got some general surgery, orthopaedics and neurosurgery and in our next budget. I am just thinking of individual numbers, I haven't added them up.

CHAIR - That's what I was referring to. So there are four areas predominantly that you'll be providing additional surgery to?

Ms HOLDEN - Yes. They are general surgery, orthopaedics, limited numbers of neurosurgery and ENT.

CHAIR - So they're the ones that are deemed to having the longest waiting times?

Ms HOLDEN - They're the ones that fall into the definitions the funding has targeted.

CHAIR - In your opinion, would that cover all those patients who fall into that category?

Ms HOLDEN - No.

CHAIR - How many would still meet the criteria if you had enough money?

Ms HOLDEN - I can't really give you that number. I think the issue for us is that we would like to see any patient waiting over the boundary of category 1, category 2 or category 3 to be treated, but that's not going to happen with $9 million - or $30 million over four years.

CHAIR - Is it over four years or two?

Ms HOLDEN - Four.

CHAIR - So the $9.2 million will be spread over four years?

Ms HOLDEN - No, that's this year's amount, I think.

CHAIR - Is it the same amount in the third and fourth years or are we looking at a bit less?

Ms HOLDEN - It is actually a departmental question - I am fairly sure it is $30 million over four years.

CHAIR - Is there anything you want to add, Jane, from your perspective?

Ms HOLDEN - I would like to say that I think the southern THO is moving on from that kind of pain of the budget cuts. There has been an understanding that if you overspent your budget someone would fund it. I think there has been a much stronger embracing of the fact that we must live within our means. That is the responsible thing for us to do and we must make the dollars we get really benefit our patients. I believe that is the underlying view of Wellington and THO staff. As I said before, it has been very impressive to see people having got over the shock that we needed to make some savings and changes, working for the benefit of patients to do just that.

Dr GOODWIN - In terms of that need to operate on budget, have you been able to negotiate the service level agreement to a point where you're comfortable you are going to be able to do that?

Ms HOLDEN - I think the short answer to that is not yet. I am presenting arguments as to why I think there needs to be some additional funding allocated, particularly in terms of the tertiary nature of the Hobart hospital, for instance. So not quite, but we are getting close to that and we have our first formal review of the service agreement in a week or so and I will continue to press that to make sure that the service agreement we reach next year is either on that mark or much closer towards it.

Dr GOODWIN - Finally, on the nurses' double-shift issue, is it possible to get a bit more detail on that in terms of the number of hours of overtime worked and in what areas?

Ms HOLDEN - Yes, I can do that. This is an area we've spent quite a lot of time on because it's not a good solution, to have double shifts. So I've been tracking that for the last 20 months and we're definitely on a downward trend, although we did peak in July and August, but I can give you that trend and I will see if I can get it by department.

Dr GOODWIN - Thank you.

CHAIR - Thanks, Jane, for your time. We appreciate that.

Ms HOLDEN - My pleasure.

CHAIR - Thank you. We have Gavin next.

THE WITNESS WITHDREW

CHAIR - Thanks for coming, Gavin. I will get you to take the oath again, if you don't mind.

MR GAVIN AUSTIN, ACTING CHIEF EXECUTIVE OFFICER OF TASMANIAN HEALTH ORGANISATION NORTH-WEST WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Thank you, and you're aware how the committee works. It is being recorded on *Hansard* and anything you say is protected by parliamentary privilege but things you say outside may not be. And if you want to give any evidence in-confidence, in camera, you could make that request and the committee will consider it.

Would you like to give us an update in relation to the topics we've been covering with the other witnesses in relation to the north-west?

Mr AUSTIN - Certainly. The north-west has - since the budget cuts - currently reduced its FTEs by 26.91, and I don't have a break down by category. One of the increased areas is in medical practitioners, so we have more medical practitioners than we had, and that is a concerted drive to convert locals to full-time staff, so it is a reduction in costs even though it is an increase in FTEs.

In terms of the winter, we only had to cancel three patients' surgery for bed-block reasons.

CHAIR - Over the entire year?

Mr AUSTIN - Over the entire winter, over the three months of winter.

CHAIR - What's happening to your waiting lists up there? We heard some information from the secretary of health, but do you have some more detail around the list waiting times?

Mr AUSTIN - I have. Our waiting lists, apart from the orthopaedics, are tracking favourably. We always have challenges with ophthalmology at Mersey because of the clinician availability and that's not a funding issue, that's clinician availability. The commonwealth rescue package for the north-west is 1.6 million for this year, and that is going into hips and knees for us - 57 additional cases. That's one a week. We commenced that earlier on in the year the minute we heard about the rescue package.

CHAIR - So you doubled your capacity then.

Mr AUSTIN - No, we've gone from one to three. We need to be doing about four.

CHAIR - That's what you were doing before the cuts, wasn't it, four?

Mr AUSTIN - Yes. It's still good, it's not quite holding the waiting list, but it's much better than we were doing before. So we are very grateful for the rescue package.

CHAIR - It is only orthopaedics that you are spending that on?

Mr AUSTIN -Absolutely - it is our biggest wait list. The minister has also allocated some additional funding to the three THOs. I think it was $4 million of additional funding this year in our service agreements and that is going primarily to endoscopies and some additional long-wait patients in a range of other categories. For us the share of that money is $670 000 for the north west which is for anyone with a long wait.

CHAIR - How many people waiting for endoscopies have a long wait?

Mr AUSTIN - Not a significant number. In terms of endoscopy wait list there are currently 556 people waiting and only 33 of those are currently over boundary. They are waiting longer than you would normally expect.

Mr WILKINSON - What is the boundary for that?

Mr AUSTIN - Category one, then category two and category three - so 365 days or 90 days or 30 days.

CHAIR - The 33 that are over boundary are they across all categories.

Mr AUSTIN - Yes. It is quite low for us. It is much better than it was.

CHAIR - How many category ones sit in that 33?

Mr AUSTIN - I would have to get that information.

Dr GOODWIN - Gavin, the $30 000, do you know how many extra procedures that will fund?

Mr AUSTIN - We are negotiating that currently in terms of our service agreement. It is a good number.

Mr WILKINSON - Are you able to give an approximate number?

Mr AUSTIN - If you were to divide it by $3 000 approximately. It will vary according to the complexity of the cases. We are still negotiating the actual numbers and cases with the funder at the moment.

Mr WILKINSON - That is a good number.

CHAIR - Matthew Daly, the secretary of health, talked about the challenges for the north west in terms of some of the contractual arrangements you have and the ongoing work with that. Can you update us on that?

Mr AUSTIN - Currently, the pathology, radiology and maternity services are all outsourced and we are in negotiations with the pathology provider, the radiology service and we have some robust discussions going with the maternity service contract holder as well. We are in the middle of good and positive negotiations with all three providers. We have no issue around their service delivery so I make that absolutely clear, but the discussions are going very well.

CHAIR - Are you confident we are going to get some flexibility there that will increase the efficiency?

Mr AUSTIN - I am very confident.

CHAIR - Oh good. What timeframe are we looking at for some resolution?

Mr AUSTIN - Maternity would be a minimum of 18 months. Pathology we should be able to resolve by July 2013 and imaging by November 2014. Early indications are very positive for some excellent returns for the taxpayer.

CHAIR - What sort of money are we looking at? Have you an idea?

Mr AUSTIN - I would venture that maybe half a million for pathology, $2 million for maternity and $2 million for radiology.

CHAIR - That would go straight back into health service delivery?

Dr GOODWIN - Which would fund a few procedures by the sound of it.

Mr AUSTIN - It would and it would deal with the north-west TOG deficit totally. That would bring the north west into a positive position.

CHAIR - Clear the debts but also provide some additional access to services potentially.

Mr AUSTIN - Absolutely.

CHAIR - One of the other issues that was raised was staff morale. What is your view on that in the north-west, across both areas?

Mr AUSTIN - The budget cuts have been very challenging. The recent service changes at the Mersey have been very challenging for staff morale. Generally, though, there is a positive attitude that we can now begin to do some strategic planning on the future directions for the north-west.

Mr WILKINSON - In relation to the specialists carrying out the operations, someone stated a short time ago that some of the specialists in training were unable to do the number of procedures to allow them to get their speciality. How is that going?

Mr AUSTIN - That was the case last year when we dropped the joints down to one a week, and that was a challenge. Now that is up to three or four a week it has alleviated that situation. It is not a problem with all other specialties.

Mr WILKINSON - So it only related to orthopaedics?

Mr AUSTIN - Yes, specifically to orthopaedics. The commonwealth rescue package funding has gone into the orthopaedic area.

CHAIR - Going back to the Mersey service delivery challenges - was the intention there more about patient outcomes or were there cost savings to be had, streamlining services?

Mr AUSTIN - It was more about patient safety. The paediatricians approached me and the commonwealth to say that doing a one-in-three roster across two sites was overwhelmingly challenging for them - to be looking after one patient in one ward at Burnie and one patient in the paediatric ward at Mersey. Sometimes it meant they were on a one-in-one call and it was exhausting for them. They couldn't see that being maintained and they certainly couldn't see us being able to attract future clinicians into that sort of model. Gen Y people much prefer a one-in-30 -

CHAIR - That's living in a dream land, isn't it?

Mr AUSTIN - Apparently in Melbourne they can get a one-in-30. A one-in-one, a one-in-two or a one-in-three is not where they want to be in terms of lifestyle. In future planning it seriously had to happen and having that one-in-three across the north-west means we can provide training, which is excellent.

The other part of the services changes at Mersey is that we diverted resources, particularly in nursing staff FTEs, from the children's ward and the theatre into the emergency department. By putting more resources into the emergency department, it means that will be able to be accredited as a training facility, too.

CHAIR - It's not your short-stay unit, it's the DEM?

Mr AUSTIN - It is the whole DEM itself.

CHAIR - Including the short-stay unit?

Mr AUSTIN - Yes. It can become an accredited training position, so we are in the processing of preparing the paperwork for that. That is a major leap forward. If you train people locally, they tend to come back and work there. It's a positive move, but it is a big change for everybody.

CHAIR - The other challenge there with the two sites was the after-hours on-call for anaesthetists and surgery.

Mr AUSTIN - Yes, we have made the surgery change as well. Surgeons have gone on to a north-west roster as opposed to on-call for Mersey and on-call for North West Regional. That is the other big change. It means patients at Mersey, if they're safe to be transferred, will be transferred after-hours to the North West Regional. If we need to open the theatres, we can because we still have staff on call and we still have the anaesthetists, because we are maintaining the maternity service there. We still have all the capability to do an emergency surgery but if we can stabilise the person and hold them in a short-stay until the next morning then we will, or we can transfer them to North West Regional.

CHAIR - So, you still do caesars overnight?

Mr AUSTIN - Yes, but it's not that common.

CHAIR - Because the midwives are very good.

Mr AUSTIN - Yes.

Laughter.

CHAIR - He knows better than to disagree with that.

As far as the savings those changes have made, what sort of figure are we talking about?

Mr AUSTIN - It's more that they have made the services safer than about savings. As I say, I've reallocated FTE as opposed to making savings to the emergency department at Mersey Hospital, which continues to grow in presentations. You heard from the secretary about our numbers dropping - that is at North West Regional Hospital, where the super clinic at Burnie has made a really positive impact. We haven't had that same positive impact at Devonport, so we are still seeing the numbers there.

CHAIR - Is that because the GP super clinic at Devonport doesn't open after hours?

Mr AUSTIN - It seems to be the key reason. We have good signage in the emergency department at Mersey, and we will continue to let people know where they can go to see a GP locally, but it's a very busy department and so we've put in extra nursing staff, extra medical staff and extra ward clerks to make it a more robust department in terms of the growth it's seeing.

CHAIR - You may not be able to answer this question. In the catchment area for the Mersey, do the majority of GPs use GP Assist after hours?

Mr AUSTIN - I don't know.

CHAIR - That could potentially be another way of reducing your presentations to DEM. Gavin, you said that if you are successful with the contractual changes, it will basically wipe out the deficit. That would be great, but what if they don't? Are there other cost-saving ventures that you're considering to be able to meet budget?

Mr AUSTIN - Yes. Similar to what you heard from Jane - our strategies are very similar in terms of what we want to achieve. We are working hard on maximising revenue. We are also doing the Proact implementation to ensure we've got the appropriate resources at the right time in the right place. We are -

CHAIR - Is that for both sites?

Mr AUSTIN - Initially, we are doing Mersey. The only reason we are doing Mersey first is because the new general manager of Mersey is very familiar with Proact; he put it in place at Wagga and he is a champion of it. He is working the change through there and then we'll roll it out across the rest of the THO. We're obviously looking at our procurement processes. We are looking at a probable media campaign about buying local in terms of your health services to encourage people, if a service exists within Tasmania, to use the service in Tasmania rather than going across the big ditch -

Ms FORREST - To New Zealand?

Laughter.

Mr AUSTIN - No. That's the other ditch.

Dr GOODWIN - Is this a problem?

Mr AUSTIN - It's a growing problem for the north-west. If someone decides they'd rather have their shoulder done in Melbourne instead of using one of our physicians and they get a referral from their GP over to Melbourne, then I, you, we all pay for that out of our health services budget.

CHAIR - Through PTAS?

Mr AUSTIN - Our interstate charging has risen from $4 million to $7 million. It's a huge increase. Some of it is very appropriate - the services that you completely expect Tasmanians to be going to Melbourne for - but there are other services that could have been delivered by clinicians in Tasmania.

CHAIR - Gavin, I thought PTAS prevented that.

Mr AUSTIN - PTAS does, but there's nothing to stop you paying for your own travel. If you've got a postcode that is Tasmanian and you have a procedure in Victoria, Tasmania will pay for it.

CHAIR - Under the new arrangements?

Mr AUSTIN - No, the arrangements have been in place for a long time, and it's something that most of us aren't aware of.

CHAIR - I don't think the general public would be aware of that.

Mr AUSTIN - No, and that's why I want to tell the general public to buy local because -

CHAIR - I hope you get a better response than the Premier got recently about buying local for Christmas.

Dr GOODWIN - What period has it increased from four to seven?

Mr AUSTIN - Over the last two years. That's just us, that's just the north-west.

Dr GOODWIN - Any particular trend in respect of the types of procedures?

Mr AUSTIN - No, it's across everything, and some of those - all Tasmanians love to buy their camper and travel around Australia, so there's a degree of that.

Dr GOODWIN - Medical tourism.

Mr AUSTIN - No, but that level of increase I believe people don't understand. You might have had the initial procedure done in Melbourne, but you're still going back each time for the follow-up and you're paying for every one of those visits. So it's a DRG that we're giving to Victoria that could be giving to the health services in Tasmania.

CHAIR - You're talking about a public hospital on the mainland, not a private one?

Mr AUSTIN - It's all procedures, it's DRG with postcode.

CHAIR - Even the private hospital?

Mr AUSTIN - Yes.

CHAIR - Wouldn't their private health fund pay for it in a private hospital?

Mr AUSTIN - If the person is elective, yes.

CHAIR - Well, yes. Just to clarify this, a patient who goes to Melbourne for a hip replacement as a private patient in a private hospital -

Mr AUSTIN - It's a private procedure, yes.

CHAIR - We don't pay for any of that at this stage.

Mr AUSTIN - No, but there is an enormous amount of us who go to Melbourne for all sorts of other things. A lot of it is completely appropriate and you would say that's fair enough, but when we look at the data there is a lot of those services that you could have obtained those same services in Tasmania, and you're paying Victoria for those services.

Dr GOODWIN - But why are they going? Is it really that they're just going over there as tourists and so they take the opportunity to get their procedure done, or what's the reason they leave Tasmania?

Mr AUSTIN - You would have to ask each one of us.

CHAIR - So there has been no look into why people do that?

Mr AUSTIN - No. We're beginning to, obviously, but it is a growing trend for the north-west.

Mr WILKINSON - In a number of cases - being blunt, Gavin - it's because people believe they can get better service over there, isn't it? I know we don't like saying that.

Mr AUSTIN - I can't answer that, but that may well be the case.

CHAIR - Perception.

Mr WILKINSON - It's perception, yes, that's right. And that is why you want to have this advertising campaign.

Mr AUSTIN - Because people won't be aware of the fact, they will honestly think it doesn't matter.

CHAIR - We might actually launch a media campaign here today about that.

Dr GOODWIN - They might think they can get it done quicker by going to -

Mr AUSTIN - I don't know. North-west waiting times are very low for most procedures.

Dr GOODWIN - And would the general public be aware of that on the north-west coast?

CHAIR - No, they're not because the *Advocate* just prints when people are waiting longer; they don't print how many have the surgery in a timely manner.

Dr GOODWIN - That could be just the perception.

Mr WILKINSON - That's right, I'm positive of that, from speaking with a number of people.

CHAIR - Just on maximising your revenue, what areas of that are you looking at?

Mr AUSTIN - One of the areas we're looking at is the clinics, similar to Jane, our oncology clinics and things like that. We are encouraging people to use their private insurance or bulk billing wherever possible, and in the past we haven't. So it's just an encouragement, and that has been made easier by the recent adoption of the radiology service to go to bulk billing as well, because private patients used to have to pay a top-up and now they don't, other than for ultrasounds. So that's a positive step for us and we're very pleased that the private provider has put that in place.

CHAIR - Why do they exclude ultrasounds?

Mr AUSTIN - At this stage we're still negotiating about that.

CHAIR - It's very lucrative, isn't it, with all the pregnant women.

Dr GOODWIN - Have you lost any specialists? Have any resigned?

Mr AUSTIN - There is always movement, but I'm not aware of any losses, other than for personal and family reasons. We've got one specialist who has chosen to resign recently for family reasons, but we are currently recruiting a husband and wife team to replace that person because we have another vacancy. It's nothing to do with budget cuts; in their case it was about family.

CHAIR - We did hear from Scott Fletcher last year about an orthopaedic surgeon and I understand one of the big challenges for him was getting enough supervised practice to meet his requirements and that was a factor. Is that a fair comment about his leaving?

Mr AUSTIN - Scott would be better to comment on that, but my understanding was there was a mix of that and some personal and family reasons. It was a bit of both and he was an excellent clinician and at that stage we were only doing one joint a week and he was worried that would not be sufficient. We are now doing three.

CHAIR - So is that the position you are replacing with the husband and wife team?

Mr AUSTIN - No, that is O&G we are looking at.

Mr WILKINSON - Gavin, we had some evidence last time as well that there seemed to be a bit of a breakdown in communication between the practitioners. This was from the north-west coast and we did not test it in the south and the north; it could be the same, I do not know, but there seemed to be a breakdown in communication between governance, bureaucracy and clinicians from the north-west coast. They believed that the services could be delivered far more efficiently if there was this communication. Has that improved over the last three to four months, do you think?

Mr AUSTIN - I believe we have put several measures in to improve that and I think if you talked to them now you would find it is a lot better than it had been.

Mr WILKINSON - Again from a non-expert in the area, but from the comments they were making to me they seemed to make commonsense in relation to overtime work, the Mersey Hospital, etcetera.

Mr AUSTIN - A lot of the changes and things we have put in place over the last few months would have addressed those issues. We have an excellent new acting director of medical services who is working robustly with me and the team to improve communication.

Mr WILKINSON - A bit of an elephant in the room I suppose, there was some debate whether there should be the three or the one THO. Do you believe that you could be doing the same work that you have been doing since the three THOs have been in action if there were just the one?

Mr AUSTIN - Under DHHS there was essentially one, so I don't have a view either way other than the fact of having a local representation for us has been very positive with the service changes we have been making recently, and the excellent support we have received from our governing council members in terms of making those changes, and being seen and heard locally is very positive. We do have really balanced community with Sarah from Spreyton towards Devonport and Emma from Ulverstone and Deb and Dale [**names to be confirmed?]**from Burnie we have quite a good geographical spread and we are getting representation and a voice heard from both sides of the divide.

CHAIR - From the Leven River.

Mr AUSTIN - Yes, and so it's really good, and they talk and argue reasonably and represent a good viewpoint, so from that point of view it's very positive for us.

Dr GOODWIN - Gavin, what are your occupancy levels at the two hospitals?

Mr AUSTIN - The North West Regional tends to be around 80 per cent and the Mersey tends to be around 60 per cent, about 48 beds. You have to remember that those numbers include all beds, so you have some wards that might be very empty and other wards that are very, very full.

Dr GOODWIN - Do you have any beds closed?

Mr AUSTIN - We have Surgical West still closed, which was part of the savings measures last year. We are accommodating these additional joints with the existing bed capacity we have. That is a savings measure that continues, but it means we have capacity to open additional beds should we have to.

Dr GOODWIN - So this extra joint surgery you're doing, you have enough capacity to cover that?

Mr AUSTIN - To absorb it. Winter was probably the busiest time since the bed challenges. During that time we only had to cancel three surgeries over the three months. That is fairly minimal.

Dr GOODWIN - You have this extra $670 000 -

Mr AUSTIN - A lot of that will be delivered in endoscopy at Mersey, which has excellent bed capacity.

CHAIR - Gavin, as far as the winter period goes, Jane mentioned she had a jump in the double-shift occurrences. Did you have a similar challenge in the north-west?

Mr AUSTIN - We did. School holidays was probably the hardest time to get casuals. People go away for school holidays and others are home looking after the children, so calling in the casuals at that time wasn't very successful. The flu-like symptoms were at a height at that time, too, so it was very challenging - and in terms of what was coming in through the emergency departments. There were a significant number of double shifts. The first time ever we had four patients being ventilated in our ICU, which is high for the north-west. We were looking at double shifts during that time.

CHAIR - That's a specialty area, though.

Mr AUSTIN - Yes, it's hard to call on a casual for the ICU. It was a challenge during that time.

CHAIR - What implication did that have on your budget?

Mr AUSTIN - It was challenging for the budget during that time.

CHAIR - Has it added to your requirement now? Jane said she'd factored in a bit of overtime in her budget.

Mr AUSTIN - We did, too. The state has been very good to us. The secretary gave us additional funding to meet our CPI targets and it has made a positive difference to our targets.

CHAIR - That was for overtime at that time?

Mr AUSTIN - Yes.

CHAIR - How does that happen? Do you make a request based on the fact that it's a challenge?

Mr AUSTIN - It was part of the service agreement negotiations. The three THOs all had a similar problem at the same time so an approach was made and it was favourably considered.

Mr WILKINSON - Gavin, looking at our budgetary problems, we had the figures come back to us a few weeks ago and we could see they were worse than expected. In relation to health and the moneys you get, is the situation that if there are any more cuts as a result of, let's say, budgetary problems, there are going to be real issues that have to be addressed? What they are I do not know, but it seems to me you are right on the Plimsoll mark now and if the budget goes under anymore we could get to a very critical situation.

Mr AUSTIN - It would be very challenging if we had to do more cuts as we did last year. That's why we are focusing on these other things such as maximising revenue and looking at our procurement processes. As to what the lead clinician group may be able to come up, it is very positive. There are some positive steps we could make in terms of health services across all Tasmania and all of us are probably ready to embrace that now.

Mr WILKINSON - The ethos was 'they are just words, empty words, we will get the money when we require it'. People now understand, It would seem, that that is just not the case, and therefore I would imagine all people are working to make it as lean and effective as possible. But it just concerns me that if there have to be more cuts, then it will have to be plan B.

Mr AUSTIN - We have run the north-west probably leaner than it should be run, and I know that the other THOs have done similar cuts, and most of my executive are carrying two jobs, a lot of our senior ministers and DONs and ADONs are doing more than you would normally expect them to do. So you've reached that plan to the ultimate.

Mr WILKINSON - And how long can those people keep doing the extra jobs?

Mr AUSTIN - I will tell you soon.

Mr WILKINSON - Because there has to be a breaking point, hasn't there; the straw that broke the camel's back?

Mr AUSTIN - And I think we're there. When we get additional tasks now we just cannot do them without bringing in additional resource; it's just too much now. But having said that, last year we probably took out $10 million from our fixed costs, which is a fantastic achievement across the north-west. This year we're looking really positive in terms of our overall direction and moving positively forward with the rescue package and the money from the minister. It's better, if you like, than it was.

CHAIR - I discussed with Graeme Alexander when he was here this morning the need to have these bloody difficult discussions about what we do, where we do it and how we do it, and for whom. Do you think the clinician group are a group that could lead that discussion more broadly?

Mr AUSTIN - I do, and I think you've got some absolutely brilliant clinicians in that group, and the three from the north-west are excellent.

CHAIR - Who is on it from the north-west?

Mr AUSTIN - Paula Hyland and Bert Shugg and Giuliana Murfet. Giuliana is a nurse practitioner diabetes, Bert is a paediatrician and Paula Hyland is our director of allied health. They are all very hard-working conscientious clinicians who do have a view to the future of services, and Alasdair MacDonald leads that group. It's a positive group and changes have to be led by clinicians.

CHAIR - We need to have a discussion first, don't we, a broader discussion with the public? That's the way you challenged us with the Mersey changes I think, wasn't it, to have that discussion with the public.

Mr AUSTIN - Yes.

CHAIR - So how do you envisage that should happen or could happen?

Mr AUSTIN - Well, at the moment the commonwealth have been having forums throughout Tasmania and getting feedback, so that discussion is happening. I facilitate workshops with the aldermen across the various councils of the north-west. So I think that discussion can be fed through politicians and aldermen in a variety of ways and people can make their voices heard.

CHAIR - Did you want to add anything else, Gavin?

Mr AUSTIN - No, just that the three THOs have worked really positively together over the winter and have worked well together at managing the challenges.

CHAIR - Thanks for coming down, being here in person. We appreciate your time.

THE WITNESS WITHDREW.

Dr JOHN DAVIS, **Dr TIM GREENAWAY** AND **Dr CHRISTOPHER MIDDLETON,** AUSTRALIAN MEDICAL ASSOCIATION WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - I'm sure you have all been here before but I just remind you that everything you say is recorded on *Hansard*, and that you are covered by parliamentary privilege while you're here. Things you say outside the committee may not be covered.

Dr DAVIS - Can I ask you about the camera?

CHAIR - That's ABC. They find it important what we do around here, which is lovely.

Dr DAVIS - Yes, excellent.

CHAIR - There is probably other print media here as well.

If there is any evidence you want to provide *in camera* you can make that request and we can consider it, but otherwise it will all be on the public record. Thank you very much. We are here to get a bit of an update, particularly after the pressures over the winter. We've had some evidence already from a couple of the CEOs and the secretary of health. We are interested in the AMA's view, particularly the impact on the medical staff at the various locations. I'll leave it up to you to tell us what you want and we will ask questions from there if that's all right.

Dr GREENAWAY - What we suggested would happen with the cutbacks, and the restrictions associated with the budgetary pressure, did in fact happen, particularly at the Royal Hobart Hospital. There were a number of occasions when the hospital was completely full. There are now two terms that are used in the hospital for the junior staff - there is 'bed block' and 'bed crisis'. A bed crisis is apparently worse than a bed block. It happened regularly. We had a bad flu season. Even if there were beds identified that could be opened, we had problems with the nursing pool shortages associated with the budgetary pressures and decisions that have been made. They couldn't find the nurses to open the beds. The situation was, as we said it would be, the elective theatre lists, for elective surgery, were reduced and therefore elective waiting lists are increasing across all the surgical disciplines. This is obviously one of the things that's been targeted with the federal money. It's a major long-term concern in terms of not only elective waiting lists but also training programs at the Royal Hobart Hospital. We predicted that this would happen and it did.

CHAIR - Has there been an impact on training programs?

Dr GREENAWAY - No, not yet. Obviously we are monitoring that, and we are very mindful of observing the effect of the federal bail-out money going into the Tasmanian health system, to make sure that money is used and spent appropriately.

CHAIR - Evidence we've had earlier, and I think it's been publicly available through the federal minister, is that the money aimed at elective surgery is to be aimed at people who have been waiting excessive amounts of time across the various areas of specialty. Will

that reduce that issue with the risk to training programs? It's patient focused, which it should be.

Dr DAVIS - If you look at the amount of money that's been set aside, specifically, for the elective surgery component of the federal government's health initiative, it's $31 million over four years, which is probably about ten operations a week if you're lucky. So we're not really making a dint in the elective surgery waiting lists through that money at all. A few patients are perhaps going to get access to care a little sooner than they might have but it is not going to change the course of the elective waiting list problem that confronts Tasmania at the moment.

Dr MIDDLETON - Adding to that, the surgical cuts that happened earlier this year were somewhat offset by the NPA funding - the National Partnership Agreement funding, coming from the federal government. That's running out now. Fortunately, the rescue package of $31 million is on line. If it wasn't for that, the surgical program at the Royal Hobart Hospital would be under extreme pressure and training programs would be affected. However, even with the increased activity related to that, waiting lists are still continuing to grow. We are not marking time; we are apparently going backwards.

CHAIR - The NPA funding you refer to, is that specifically the elective surgery funding?

Dr MIDDLETON - That is money made available through the federal government and specifically targeted for elective surgery but I'm informed that is coming to a close. The next package, courtesy of the federal minister, is very welcome. Without that, the hospital would be in real trouble.

Dr DAVIS - One of the other issues we have to be careful to watch is the $56 million, I think it was, that has been set aside for training, in that allocation of funds over four years. The worry will be that we will simply fund jobs, and the people who have those jobs funded won't have access to patients to care for, which is the point of training. We cannot just use that money to pay salaries to doctors, either in the private or public sector, to get through a year of work. If they do not do the correct caseloads the year will be wasted so we need to monitor very carefully that we are not just funding a job, we are providing the access to training. If we can do that we may make a dent in elective lists because patients will come through.

Mr WILKINSON - Has there been communication with you in relation to knowing there is a problem and how do we solve it - bureaucracy and yourselves?

Dr DAVIS - I am not sure anyone has come to us using exactly those words. We meet intermittently with departmental staff and the minister. They are aware of our concerns, both short and long term. We have written to the federal minister when the 'bale' package, for want of a better term, was put in place and we offered to play an active role in assisting both the federal and the state government to best use that money for the benefit of Tasmanians. We had a letter saying thank you.

Mr WILKINSON - That is it?

Dr DAVIS - Nothing more. Which was not surprising, realistically

Mr WILKINSON - That is where I was coming from on the last occasion. The best way to endeavour to fix it in the best way you can, is by getting parties together and saying we are on the ground, we know what it is like, we are dealing with it day in and day out, we believe we can fix it this way. You offered to help and they have said thank you and nothing more.

Dr GREENAWAY - I think the establishment, finally, of the lead clinicians group is a positive step and the commission that will look at service delivery that is being chaired by Alistair McDonald will have a very important role in looking at how this all plays out for the state. We see that as a positive step.

Mr WILKINSON - It seems that the real problem is not enough money.

Dr GREENAWAY - Yes.

Mr WILKINSON - So you have to deal with the money you have the best way you can.

Dr GREENAWAY - It is also about access and equity. We do not see why Tasmanians should not have access to and equipment standard of healthcare as our colleagues on the mainland. It is a way of trying to ensure that the government is held accountable for decisions that it makes in terms of the impact of cuts on the delivery of fundamental services that are the right of all Tasmania.

Mr WILKINSON - If you were made health minister tomorrow what would you do?

Dr GREENAWAY - Do you seriously want to know what I would do?

Mr WILKINSON - Yes.

Dr GREENAWAY - I would have one THO, one funder. A funding model for Tasmanian health. The AMA is on record as supporting this. The three-area health services, even though it has only just been put in place, is a potential issue.

CHAIR - The AMA have shifted their position on this then?

Dr DAVIS - No. If you recall when you were debating this last we came to you and said we think that the game had moved beyond THOs. We recommended to you that you pull the pin on the whole THO process.

CHAIR - And then get no money from the feds?

Dr DAVIS - The state is in absolute crisis and if we do not fix it, and fix it once and for all, we will all be back next year, and the year after, wondering what we can do. We do not need just one funder, we need to remove politics from the process of making decisions about how health dollars are spent so we do not build concrete bunkers on the north west coast for $20 million, which will never be staffed, by the beautiful new bunker and a new machine. Just no staff and no care. That $20 million could be used very valuably in the Tasmania health system.

CHAIR - Don, could I stop you there for a moment because the committee has had evidence that it will be staffed and it will be run.

Dr DAVIS - That may well be the evidence you have received but as clinicians here in Tasmania,

Dr GREENAWAY - There is an international shortage of radiation therapists.

Dr MIDDLETON - It will be very difficult to support that unit by cannibalising services which are already run well.

CHAIR - The intention was always going to be with Launceston or Peter MacCallum clinic.

Dr GREENAWAY - The issue has to be rationalisation and you have to cut your cloth.

Mr WILKINSON - Tim, please, anybody that can help with that. Getting back to the question, the first thing you would do is have one THO?

Dr GREENWAY - One funder.

Mr WILKINSON - One funder.

Dr GREENWAY - There has been the Wellington report, the Richardson report, all of these reports, that were very worthwhile reviews and came up with sound suggestions that had never been taken up because of the political difficulties of a parochial environment implementing difficult decisions, but somebody, sometime, for the sake of all Tasmanians, is going to have to have the fortitude to make those calls.

Dr MIDDLETON - The three elements of the Rudd reforms were single funder, local administration to make sure the funds actually arrived at the coalface, and clinical engagement. It looks like we might be getting clinical engagement in terms of the lead clinicians group, I saw that was announced yesterday, so hopefully that -

Dr GREENWAY - That is a plus.

Dr MIDDLETON - Hopefully, that will go some way to enabling a statewide view because half a million people, a dispersed population, and everybody with a parochial attitude leads to the situation that we currently have at the moment. We need the people who are able to take a broad view and work out what we can reliably and safely provide in which centres. That is hopefully what we are going to get, that clinical engagement which will permit that. We do have local administrations, whether they are quite as lean as Rudd envisaged, I am not quite sure - whether the total administrative employment of the three THOs is any less than was in the DHHS plus local, whether it has been leaned out.

The other main problem is the single funding. We don't have that and so it still allows the feds and the state to kick it between themselves and tell the poor patients that it is the other party's fault when they are not getting care. As Tim said earlier, it is iniquitous that Tasmanians don't have access to the same level of care that is available in metropolitan Australia elsewhere and that should be the focus of these sorts of committees, to look at how we can arrange a system where there isn't this cross-shifting, blame, et cetera.

Dr GOODWIN - Is that the main issue you see with the single funder, around trying to prevent the blame game, the cost shifting?

Dr GREENWAY - A single funder with local administration would have a chance of being more efficient, should be more efficient, but would allow for the debate that we have to have in terms of what services can be provided safely and efficiently in which areas.

Dr GOODWIN - You do not think we can have that debate in the absence?

Dr GREENWAY - We have not had it successfully, otherwise we would not have four hospitals in a state of 500 000 people - it is just ridiculous. I used to think living in Sydney that the parochialism between Sydney and Melbourne was an issue, but I knew nothing until I came here.

Dr GOODWIN - You are not confident even with this lead clinicians group and the -

Dr GREENWAY - No, I would give credit where it is due. I think that is a positive step and it does involve senior clinicians who are experienced clinicians from the three regions and the conversation can be had. I expect and I hope that they will lead the debate and lead a discussion about what we can afford to do and what we cannot afford to do, how we manage health better and how we improve the delivery of fundamental health care to Tasmanians.

CHAIR - This is what has been lacking. I agree that this discussion is a difficult one we have to have.

Dr GREENWAY - You would know from your clinical experience.

Mr WILKINSON - From what you say with this lead clinicians group, it is the best situation we have been in for a while for people who know what they are talking about to be able to hopefully have some influence because they will be able to speak with the others.

Dr GREENAWAY - The key though - and I can speak independently again of John because he is on the committee - it is whether they will be listened to and whether their recommendations and their advice are heeded.

Dr MIDDLETON - And adequately resourced.

Dr GREENAWAY - Yes, absolutely and obviously we will be watching that.

Mr WILKINSON - When will we start to see and hear whether you have been listened to? For years I've been saying you've got to listen to the people who are in the bullring fighting the bull. If you don't, you've got problems, but now it seems like they're in the bullring - they're starting to do the work I think is needed.

Dr GREENAWAY - Agreed, but we are going to have to wait and see what happens. But it is a positive step, or we view it as a positive step.

Dr DAVIS - We do need to go back to one funder and one funder isn't necessarily one government or the other, it's just the process by which we fund. The Brits have set up a board that has an academic component, a service component and an administrative component, and all funding for the institution or the region comes through that board, and there is no ad hoc political funding.

CHAIR - One board for the whole country?

Dr DAVIS - I would suggest we have a board like this for Tasmania, so that any health expenditure comes through that vehicle, whether it's for training - undergraduate, or post-graduate - or service administration or research. The board disperses the funds in the best interests of the system, and there is no political interference in the board's decision making. And that's the -

CHAIR - We've essentially got that now, but in three areas.

Dr DAVIS - We don't.

CHAIR - Well, isn't that where we're trying -

Dr DAVIS - We've got a federal government and a state government, both of whom will come to an election in the next 12 and 18 months and we will get health promises that will be politically driven. We've got to stop the capacity to continue to destroy the health system by virtue of electoral decision making for the benefit of one party, or one individual or the other.

CHAIR - I agree. The funding model we got under the three THOs is still a mess. It was quite complex - effectively the money was poured in one end from both the commonwealth and the state. There was more than one point of entry. It went into this one area to then be dispersed to the THOs. And that was where the decisions were supposed to be made - the government didn't decide. But whether it will work that way, we don't know.

Dr DAVIS - We've got lots of the rest of health being funded away from the (inaudible). We've got a Medicare Local in the state now, which is getting truckloads of money and it's being spent completely in isolation from the THOs. So the left hand still doesn't know what the right hand is doing and neither side knows what it is thinking. So we've got to have one area - it all comes in to one place and one place makes the decisions and distributes.

Dr GREENAWAY - On Tuesday afternoon Chris and I attended the commission into the delivery of health services - the commission that is going to look at how the federal money is administered. We were divided up into 12 tables, or something, where the participants had to identify problems, and list potential solutions. Every single table said one of the options would be to get the politicians - with due respect - out of health.

CHAIR - Well, we've had too many political decisions made for too long.

Dr GREENAWAY - Yes, and that was a consistent theme in the discussions that we had.

Mr WILKINSON - It's going to be hard to do that, though.

Dr GREENAWAY - Understood.

Mr WILKINSON - That being the case, how do you work with that?

Dr DAVIS - It's not hard if there is genuine will to restructure the health system and to recognise we've got an older, poorer population, who are sicker. That's the problem we're confronting. And that is only going to get worse, and the cost of delivering health care to individuals is going to become more and expensive. If we don't bite the bullet soon and begin to correct the problems, then the small tsunami we're being confronted with now is nothing like the one that is going to hit in 10 years, when we just can't deliver health care. That's where we're going to get to - not delivering health care.

Mr WILKINSON - It sounds like it's easily achievable, but I think you would realise -

Dr DAVIS - Well, if Tim was health minister it would be achieved.

Mr WILKINSON - Yes, that's right.

Dr DAVIS - No, I wouldn't last very long.

CHAIR - But, is he Federal health or is he state health minister?

Dr GOODWIN - This would be across Australia, health minister for the whole of Australia

Dr GREENAWAY - This is the other great thing about Tassie. We are a small population completely isolated from the rest of the country. We can offer the rest of the country a unique insight into the future of quality health. We are all here sitting and talking about the problems in Tasmania. Queensland, New South Wales -

Dr GREENWAY - They are all following us.

Dr DAVIS - They all have just as big a problem, it is just that they have slightly bigger bankrolls sitting behind them.

Dr GREENWAY - We talk to colleagues and they say they are watching what is happening here because they reckon -

CHAIR - It is coming to them.

Dr GREENWAY - It is coming to them.

CHAIR - To a state near you.

Dr GREENWAY - Indeed. But they are looking for the reasons that John has mentioned - we are half a million people, we do represent an opportunity to change things or at least to model the delivery of health care differently and maybe make a difference. As John said if we don't then we are just deferring these tough decisions to our children.

Mr WILKINSON - It fits in with our branding as well, and that is where I am trying to get to. We're clean and green, the university is doing well - if you have good healthcare as well people will want to come down. Terrific place to live, good healthcare, good education.

Dr DAVIS - And the private sector in health wants to be engaged in this all-in solution. They are not saying, 'Let's watch the public sector sink.' They are saying that the problem is statewide, and we all need to be there.

Mr WILKINSON - Getting back to the clinicians group - no doubt you will be calling out loud and clear that this is what has to be done? It will be interesting to know, or is it too early to know whether your suggestions are being taken on board?

Dr DAVIS - It hasn't met, it was only announced yesterday.

Mr WILKINSON - Haven't you met yet?

CHAIR - Expecting a bit much, Jim.

Dr DAVIS - It is a really positive step forward, there is no doubt about it.

Dr GREENWAY - And we have been arguing for it for a long time.

Dr DAVIS - Let us hope it does make a difference.

Dr GOODWIN - Getting back to the impact of the cuts, particularly to elective surgery, and also to doctors and specialists, and the broader impact. What have you noticed since we last -

Dr MIDDLETON - When we were here last time I sent around some emails beforehand to colleagues to ask them where things were up to. I sent another email earlier in the week to ask if there has been any progress since we last asked it. Some of the evidence that was tabled last time included a letter from Andrew Hunn and he was happy enough to provide it. I asked him if there has been any progress. He responded, 'In a word, the same'. There are 900 patients waiting to be allocated a clinic in neurosurgery. So these aren't people who -

Dr GREENWAY - They haven't even seen the doctor and don't know when they are going to.

Dr MIDDLETON - They are waiting to be allocated - 263 on the surgical waiting list and approximately 1 000 on the active clinic list. With those sorts of numbers and that sort of task it is very difficult to see how that could be improved at any time in the near future without a significant injection of funds and resources.

Dr GREENWAY - Our information, and we work in the system, is that waiting times are increasing across the board for everything.

Dr GOODWIN - Are any specialists being lost to the system because of what is happening, or is that a risk?

Dr GREENWAY - It is certainly a risk. Particularly for surgeons whose training programs require that routine operations need to be done. Surgical trainees need to meet mandatory requirements for training. If the lists are reduced and there isn't access to theatre time and those operations are not done, the trainees won't come. Senior specialists work in teaching hospitals and if the trainees are not there, then they will go somewhere else.

Dr GOODWIN - The other issue we heard about this morning is the morale issue and the suggestion is that it is pretty well at rock bottom across the board.

Dr GREENWAY - I think the hospital is aware of that. This is outside the terms of reference of this committee, but, for example, the Salaried Medical Officers' Award is currently being negotiated and the focus of that will be on conditions for junior doctors and trainees to try to make them feel that they are part of the system, belong and are valued. Morale is an issue for all levels of staff - medical, nursing and allied health. Nursing cuts have meant that many young nurses are looking at the potential consequences of these cuts on their future training. It's not just medical morale that's affected.

Dr MIDDLETON - That's what one of the paediatricians writes but in the paediatric nursing course, I think we lost a number of our recent graduates from the course. They could not be offered ongoing work. What a waste of training. These are people who would be snapped up if there were funds available to employ them. It's across the board, not just the medical staff.

Mr WILKINSON - In the work that you're doing, are you looking at what hospitals do what operations? Is that what you're talking about as well?

Dr DAVIS - In terms of?

Mr WILKINSON - In terms of endeavouring to deliver the best service. You've got one THO; you're saying maybe not even a THO, maybe a board where all the money comes in and filters out in accordance with what the board believes.

Dr GREENAWAY - I think that four hospitals in a state of 500 million [he means 500 000] is clearly too many. At least, the services need to be around four generalised hospital systems.

CHAIR - In the north-west, you've got to admit the change of ?MA there to make it one hospital -

Dr GREENAWAY - I agree.

CHAIR - It is one hospital. They don't duplicate much now.

Dr GREENAWAY - I agree, changes have been made but that needs to be progressed so that the discussion has to be had in terms of what things are appropriately delivered in which areas.

CHAIR - The challenge to that is the federal intervention. They couldn't progress the health plan.

Dr GREENAWAY - Yes but in a couple of years, of course, the Mersey [Hospital] comes back into the state -

CHAIR - Potentially.

Dr GREENAWAY - Potentially. That really will be an issue.

CHAIR - Discussions need to be had before that so that the direction can be clear.

Dr GREENAWAY - I agree.

Dr DAVIS - I want to take up the area of morale. The other area where morale is often forgotten is in general practice. The consequences of what is happening in the public sector is low morale in general practice. General practice is now seeing more and more cases of patients waiting longer and longer and getting sicker, waiting for, often, the opportunity to see a consultant and have a diagnosis made, let alone begin the process of providing care.

CHAIR - And being put onto a waiting list for surgery.

Dr GREENAWAY - Potentially, but there are waiting lists for medical reviews as well.

Dr DAVIS - There is a new one which I heard the other day; they now have a 'planned waiting list' where you are just a name in the system and eventually when they get around to planning the waiting list, you will be considered for a place on that waiting list. If you are a patient with -

CHAIR - A list for a list.

Dr GREENAWAY - Yeah.

Dr DAVIS - Yeah. If you're a patient waiting in care , it's is soul-destroying for patients and for general practice; you're confronted by patients in this dilemma multiple times every day. There is nothing meaningful you can do for them.

Dr MIDDLETON - One of my more vocal general practitioner colleagues, when I was living in Launceston, used to bemoan the fact that he spent so much of his day propping up patients who should have been receiving definitive care from the hospital. He was constantly seeing these people and trying to patch them up while they were waiting to have their hips done or their gall bladders out or whatever. He didn't have time to see new patients because he was spending a huge waste of resources.

CHAIR - They are perhaps access issues for GPs.

Dr GREENAWAY - Yes.

Dr DAVIS - Yes.

Dr MIDDLETON - Yes; this is in areas where access to GPs is already under threat.

CHAIR - Yes, that's right; or challenged.

Dr DAVIS - This is again where you've got the increased cost to the system; it's another system. Medicare is paying enormous sums of money to have people propped up. The Pharmaceutical Benefits Scheme is shelling out enormous sums of money to prop people up because they are federal problems and the state is not delivering the definitive care to stop all of that waste.

CHAIR - This is the whole cost-shifting thing.

Dr GREENAWAY - Exactly.

CHAIR - So [you prefer] one funder.

Dr GREENAWAY - One funder; one board.

CHAIR - We're out of time, gentlemen, but are there any closing comments you want to make?

Dr GREENAWAY - Thank you for listening.

CHAIR - If you have a silver bullet you can send it in the mail.

Dr MIDDLETON - I have one question. I've read your interim report and it seemed to be full of a fair bit of angst about how you couldn't get information out of the government.

CHAIR - The minister, yes.

Dr MIDDLETON - Is that situation resolved in any way?

CHAIR - We did eventually get some material under summons which was helpful but the minister still chose not to appear before the committee.

Dr MIDDLETON - Right, that's surprising, isn't it?

Dr GREENAWAY - That tells you something in and of itself, I would have thought.

Mr WILKINSON - Can I just ask you this: when do you think you'll be able to see whether any outcomes have occurred as a result of the clinicians?

Dr DAVIS - I think it will depend on what resources the clinic is given and how it decides to task itself rather than being tasked. I've had nothing other than a letter inviting me to be a member and I've accepted but I've heard nothing more.

Dr GREENAWAY - We know the members and we know the Chair.

Dr DAVIS - We don't know yet what is planned.

Dr GREENAWAY - We will watch.

Mr WILKINSON - So will we.

CHAIR - Thanks for your time.

THE WITNESSES WITHDREW.

CHAIR - If you just wouldn't mind taking the oath again, Frank, it would be appreciated.

Dr FRANK NICKLASON WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED

CHAIR - Thank you. Now, just to remind you that everything you say is being recorded on *Hansard*. You're protected by parliamentary privilege while you're here but anything you say outside may not be. The media were here earlier but they're not around at the moment but they may come back. If there is anything you want to discuss in camera you can make that request and the committee will consider it.

We've just had a bit of an update from the impacts from the cuts, particularly over winter. Last time you were here we talked about the survey that you did with medical staff. Any updates on that?

Dr NICKLASON - I did that survey which really indicated a feeling of disengagement of senior medical staff with the administration. I don't have any doubt that that is an ongoing feeling, though I do think that there have been some decent efforts on behalf of the administration at the Royal to try to address that. We are pleased with that and I think it's starting to bear a little bit of fruit. The temperature of the Royal was pretty red hot around the time that I did the survey and there was a rapid, enormous response rate. I did do another survey just a couple of weeks ago and you can tell what's going on by the response rates. There hasn't been much response. A few people have responded and I left quite an open area for them to make comments. There were some useful comments.

The obvious thing in talking around the place is that the temperature has gone down. There were some good things that have happened.

CHAIR - What sort of good things, Frank?

Dr NICKLASON - One of the things that I got from talking to the surgery and anaesthesia department is that the federal money is starting to be put to good use. One of the examples of that is probably quite instructive and that is that the Division of Surgery have employed a fellow in surgery, someone who is just qualified, but good enough to be able to be a competent surgeon and do lots of operating and teaching.

CHAIR - A general surgeon?

Dr NICKLASON - Yes, a general surgeon. He has been put on and has been nose to the grindstone doing a lot of surgery, laparoscopy, cholecystectomy, hernia surgery and so on. These are things that tend not to get a very high priority normally, but there is quite a bit of morbidity and potentially quite serious complications of leaving things unoperated on, so he is going very well and really that has been a very useful thing to have happened. I think it has probably indicated a model of what could be helpful.

As you are probably well aware, most of the surgeons in the hospital are visiting medical officers. Many of them, for instance in the orthopaedic area, have relatively small hours that are paid for by the Royal. We are very lucky to have excellent orthopaedic surgeons

in town but I have heard them say very often there is a feeling that they don't have enough time to be able to really put the hole that they would like to put into the waiting times for large joint replacements, hip and knee.

CHAIR - They do not have time because there is not time available in the theatre?

Dr NICKLASON - There is a lot from their own time. With surgery you have to get every number right, just as you do when making a phone call. There are so many things that have to happen before an operation happens. You have to have the patient in the right condition, you have to have a bed available for them to come into, you have to have the theatre space, you have to have the surgeons and all the theatre staff and very often the after care as well. All of those things have to line up. One of the problems has been that the emergency theatre time isn't quarantined or the elective theatre time isn't quarantined, so sometimes an emergency will displace an elective operation, so that is intensely frustrating for the person who has a knee that needs fixing.

One of the problems in an area like orthopaedics is the surgeons having enough time that they can do that. They are all VMOs, they are all exceptionally busy in the private sector and in some ways the financial rewards of working at the Royal are significantly less than working in the private sector, so that model potentially of having a fully trained surgeon who is not yet entering into private practice spending a year or two honing their skills and putting a hole in the waiting list seems a good model and it has certainly worked in the general surgery area. Whilst I do not know whether there are any plans I would suggest that it would be something that would be in favour in these other areas.

Another one is cataract surgery where there is a lot of morbidity of not getting the operations done potentially. There are some others, plastic surgery is another one, so things that needs to be done in plastics can cause a lot of problems if they are not operated on soon.

Mr WILKINSON - So the temperature is down a bit and people aren't as uptight as they were? Can people see light at the end of the tunnel or do they believe that this is a blip in the radar that is going to return to where it was?

Dr NICKLASON - I don't think that people would say a light at the end of the tunnel is the feeling. I think that most people who have been in the system a fair while recognise the ebbs and flows and that we are in a relatively calm period and that things just move like that. That is certainly my experience, having had a 17-year stint this time at the Royal. Having said that, I don't want to make that a completely negative statement. I think that definitely there are things that have been positive. The issue about engagement of senior staff to try to help with some of the decision-making is not a completely resolved thing, although moves in the right direction are being made. Very often the mentality is that we will get a bit of relief and then we will go along and then another problem will occur, so it is a chronic relapsing sort of situation.

Mr WILKINSON - Do you think that the boards now with the three THOs - I would rather one, but that is my personal view - but with the three THOs, and especially with the leading clinician group, do you think they're going to be able to give some good advice to people, because you have the people at the workface finally being able to say that we believe this might help or that might help. Do you think that is going to be of assistance?

Dr NICKLASON - I hope it will be. I have looked at the composition of the lead clinicians group and it has the right type of people. I can't really say yet. I have a great deal of confidence in Matthew Jose, who is our professor of medicine here, and I haven't had time to talk with him about it, and there is not yet time to evaluate how useful it will be. I think in principle the mood is right to have that.

CHAIR - Who are the southern members, Frank? You've got John Davis and Matthew Jose.

Dr NICKLASON - Yes, John, and Matthew Jose is our professor of medicine. There is a northern GP named Leanne Jones, and some nurses that I don't know that well. I can't remember all the others.

CHAIR - It was only announced yesterday, so you're forgiven.

Mr WILKINSON - It has been a problem for many years and it always will be. But hopefully now people are starting to understand that unless something is done, the problem is only going to get worse, but it seems like there are some plans in place now that probably haven't been in place for quite some time, and people now are realising that something has to be done, otherwise it is only going to spiral.

Dr NICKLASON - That's right.

Mr WILKINSON - Is that right?

Dr NICKLASON - Yes, I think so, yes. I don't know how much the conclusions of this meeting, committee, can help. I do think it's good to know that that model, that fellow in general surgery, that it looks like it's working really well. I think it's good to know that, and to have that as a piece of information and to suggest that perhaps that can help in other areas, those key areas, where there is really important elective surgery that can be done.

CHAIR - This is where you need to know where the biggest or the longest waiting times or the most out-of-boundary patients are. If they are all in orthopaedic surgery you're better off getting another orthopaedic surgeon rather than a general surgeon.

Dr NICKLASON - Yes. I think that the general surgery was important, but orthopaedics is critically important. There is so much at stake when people can't move properly and the deterioration that occurs in so many different parts of their lives when that is not addressed and the extra time that takes to get them going. I don't need to tell you that. I would imagine that's very high on the list. I think cataract surgery is probably very high on the list as well and that people shouldn't have to wait too long and vision is so crucial.

I think they would be two to hear the information about, what their waiting lists are. I know that they are long, I can't give you the details of them, but they're too long, and I have to refer some patients for large joint replacements and it's always difficult. You know your colleagues would love to be able to do it quickly, but they can't.

Mr WILKINSON - Frank, you've been in the system at the Royal Hobart Hospital now - I know you were there beforehand - but 17 years up to now.

Dr NICKLASON - As a consultant.

Mr WILKINSON - Are you able to say in relation to morale, whether it's better than it has ever been, or not as good but improving or, 17 years ago it was terrific.

Dr NICKLASON - I think that there has been a significant improvement in the last few months compared to what it was when the budget cut announcements and the rapidity of what had to be achieved was really something that profoundly worried people. It wasn't just the budget cuts that were of concern, it was what went with it, that really forced the administration of the hospital to micro manage and that sort of micro management meant that people who had been in very senior areas in departments had some of their ability to manage their department questioned and taken away, and taken away some of the executive decision-making processes. Sometimes very senior people, running incredibly successful departments, world-class departments, like hypobaric medicine and other departments, those people being not able to sign off on something like conference leave, or other leave requests, or something. It is silly.

It also means that there can be a slowness in filling a position that is really necessary. That phone number analogy, where you have to get every number right, where so much of what is done in hospital these days is very complex. It requires a number of different specialties working closely together to achieve it and if there is one discipline missing from that team that provides that care, it can make a very big difference. There needs to be some autonomy in these decision-makings, so that people can quickly move and fill those positions. Of course there needs to be good clinical governance, so if people are making bad decisions that comes back to them.

The overall mood that I very much detected in the first survey was that issue of micromanagement. I do not think there was a strong blaming thing - no one suggested that any particular person was a malignant micromanager, but the realities of the budget and what was expected created that situation.

Dr GOODWIN - We heard evidence that clinical staff did not feel at all engaged in that process. It was dropped down and imposed on them and then micromanagement on top of that. It is interesting we heard evidence that there was an obvious impact of winter. It is interesting to hear that despite that winter peak -

Dr NICKLASON - It is better than it was. I still detect a fair amount of negativity at times, but I can report on some better things than I did last time and whilst that is not universal it is there.

CHAIR - Regarding the negativity, what are people most negative about?

Dr NICKLASON - I still think there is a feeling of disengagement. I think the people who have tried to bridge that gap see that there is some progress being made. I think people who are more distant from that process are yet to see the benefit of that. I think there is still concern with those things that I mentioned about too much time to fill a position that is critical.

CHAIR - Is that because those people aren't available?

Dr NICKLASON - Definitely not always and sometimes it is a delaying tactic that saves a bit of money. Another comment that was made that was really important was this business of being able to set a good succession plan for a department. Many departments contain people who are going to retire in the next 10 years and you have to be bringing on someone new. You have to convince those people that you want to bring in to your department that this is a go-ahead place, it is not too dysfunctional, that the award is important as well, and it is important as much as anything in the differential that exists. Those sorts of things.

CHAIR - Are you aware of specialists or medical staff resigning as a result of their frustrations because of the funding cuts? People often have a range of reasons for leaving and it is not often just one reason?

Dr GOODWIN - Or thinking about resigning.

Dr NICKLASON - I do not have a lot of stories about that. There is one person that I know of who has left public orthopaedics.

CHAIR - In Burnie?

Dr NICKLASON - No, here.

CHAIR - Here in Hobart. But still doing private?

Dr NICKLASON - Yes. I think a bit of frustration there and you probably know who I am talking about. There may be others. Not from the medical side where I am working.

CHAIR - Do you feel that there is already, or could be, threats to the training programs for your registrars?

Dr NICKLASON - There was a lot of concern in the surgical training program and that concern is currently dissipating.

CHAIR - Oh, has it? Why is that dissipating?

Dr NICKLASON - I think partly because of the money that is coming through the federal area. I think that having this surgical fellow that I mentioned working and doing some teaching has eased things. It's a matter of being able to have the volume of caseload that justifies being a training physician.

Mr WILKINSON - Has it affected the Menzies Centre at all?

Dr NICKLASON - Not that I know of. I am probably not the best person to ask that question. I think if there was a major issue I probably would have been told. Tasmania is very lucky to have this cardiologist, Tom Marwick, who is regarded as one of the international people in cardiology. I think there was some concern because he wanted to have a couple of sessions at the Royal, and for some reason or other that has not happened when it should have obviously happened. One of the cardiologists came up to me, in fact the head of the department of cardiology, and was very disappointed. If

you've got a guy of that stature in the hospital the red carpet should have been rolled out in front of him. But it didn't seem to be. I don't know if that has been resolved. It seems a bit ridiculous.

CHAIR - How long has he been here?

Dr NICKLASON - Less than a year I think.

Mr WILKINSON - Getting off the point a bit but it seems to me, if we can trumpet the fact - we talk about our clean, green image. We talk about the healthy lifestyle that can be led in Tasmania.

CHAIR - We just don't look like it as a population.

Mr WILKINSON - Well, we don't. You walk through town and you don't look like it. I spent a number of hours, not for me but for another, in the emergency section of the Royal. It was pretty sad viewing really, extremely sad viewing. If we can have a really top-class medical system - we've got the Menzies Centre - to me it would be an attraction to come down here to live, to be a doctor and to give our intellectual capacity and capital in Tasmania a boost if that was the case.

Dr NICKLASON - Absolutely. There are people in the Royal whom I respect a great deal. Marcus Skinner, whom you know very well, talks exactly like that and it's not unrealistic. That could happen. It's just a matter of will and people with the determination and drive to make that sort of thing happen, and why shouldn't it happen here? It should.

Mr WILKINSON - Then it would seem if we do have a good system in place that can flow into your obesity question, get the people that are struggling hopefully into some fitness campaign, your diabetes, all those things. I think Tasmania would be a good experiment.

Dr NICKLASON - It is because it has a confined population, a relatively stable population. It's great for an epidemiological study and it's small enough that if you just have the will of the politicians and bureaucracy you could make a lot happen to make the city less dependent on cars and have more encouragement of active transport. It would be a really big start. When you go and see those cities that I was telling you about, Amsterdam and Copenhagen, you just don't see the fat people that we have here in Tasmania. They look different; they are different. It's a different sort of feeling that you get when you are in these places. And don't tell me it's the hills.

Laughter.

Dr NICKLASON - There is a picture of a guy with one of those e-bikes in the paper today. I had a ride on one of those.

CHAIR - An e-bike?

Dr NICKLASON -Yes, it had a little battery charger so you get a bit of a boost. You still have to pedal fairly hard.

Mr WILKINSON - You obviously know the medical system well, not only within Tasmania but the rest of Australia; are the other states in Australia going through the same issues that we're going through, is it worse or the same?

Dr NICKLASON - Yes, there is a really useful book called *Restructuring Medical Care* by a woman named Christine Jorm(?) who is from New South Wales, and she is a very esteemed anaesthetist and she did a PhD which was basically surveying very experienced medicos, surgeons and physicians of all different specialties, and she found exactly the same level of disengagement and concern about disengagement. And she sees it as a world-wide phenomenon that has occurred over a period of about my working life, which is about 30 years.

It's hard to say exactly why that happened. It's a different managerial style perhaps. It's hard to be sure, but a very common theme that you get when you talk to a medico who has been around a fair while now is that 'management doesn't really listen to what I say; there is no point engaging; I'm just going to look after my patch'. It's actually a dangerous sort of attitude to have. It's understandable, but it's dangerous because then there are things that management have to know from us and there are things that we have to know from them, and the disconnection doesn't help.

It's a worldwide phenomenon and I don't think we're necessarily any worse. We've got particular challenges that were well flagged around the time of Minister Plibersek coming here, which were our dispersed population and the political problems that go with that, the ageing of the population, the heavy chronic-disease burden, we've got all those things, they're particular problems in Tasmania. They require a response that is far broader than the health system, it requires real -

CHAIR - Plus housing, poverty, education.

Dr NICKLASON - Housing, transport, lots of things. Education would be the area that you would concentrate on most.

Mr WILKINSON - The Heart Foundation has brought out a program, hasn't it?

Dr NICKLASON - Yes, that's right. So I think that's emphasising that all of the department and all ages have to be involved in it; it's not just you expect this to happen because of enlightened health policy.

Mr WILKINSON - Yes, okay, thank you.

CHAIR - I think you said you read the interim report. One of the comments made was about the lack of workforce planning. You mentioned that's within your succession planning and that sort of thing. How do you think - the government are talking about refreshing the health plan as a way of looking at those issues generally, about how do we look at the workforce needs into the future. How do you think that is best addressed? There was also criticism of the number of medical students. We're training too many for the intern placements and possibly nurses too.

Dr NICKLASON - I haven't really given it as much thought as I should have, to be honest. I think one of the things that really slows people down in succession planning is when

they're having to fight just to survive. It's when there is a feeling of security of resources that then you see departments making succession plans, and so some of it comes at a department level. I've heard a lot in nursing about the disappointment that there has been training of some excellent young nurses and then for them to be lost interstate and we know that many of them don't come back. We know that there's very significant ageing in the nursing workforce and in the medical workforce. In general practice, some of the services provided by general practitioners that have an impact on the hospital such as providing nursing home care, are being done by GPs who are much older than the average GP and who will be retiring. There are things like that which could potentially have a really serious impact. It's the data that informs that so when you know those demographics of who is supplying those services, it becomes obvious that some areas need a lot of attention.

Mr WILKINSON - If you have the reins for a day, would you be doing anything differently?

CHAIR - Give him a week.

Mr WILKINSON - Maybe a week.

Dr NICKLASON - There are some exceptional people who work at the Royal Hobart Hospital and there are some exceptional departments. I'll mention hyperbaric medicine but there are others as well that are exceptional. I don't think the hospital leadership, let alone the Health department, understands that.

What I would want to do if I was CEO for a week would be to employ someone who I could completely trust to tell me who those people are and to make sure that I know what those people are thinking and if they have any problems, I can hear about them and try to solve them.

CHAIR - Or any ideas, because they are probably the ideas people as well.

Dr NICKLASON - Yes. It's important knowing those key people, knowing what they are doing, knowing the services that they are providing, knowing how they are going, whether they're vulnerable. Some of those things have evolved over quite a considerable period of time. If they are lost for some reason, then there is a really big problem. It can take a generation to restore something like that.

Mr WILKINSON - Do you think we do it well enough, though? To me, hyperbaric expertise should be trumpeted a bit. It should be in the newspapers, it should be heralded as being world-class, which it is.

Dr NICKLASON - Yes.

Mr WILKINSON - People who are there know it. People like yourself who are close to it know it. Not many people know about it, though, do they?

Dr NICKLASON - I wish that would happen. This week there was a lovely story in the *Mercury*. We had the top graduate in anaesthetics.

CHAIR - With his father.

Dr NICKLASON - Yes, Anders Bown. The story wasn't quite good enough, if there is anyone here from the *Mercury*. It didn't say what Anders said. What I know he said was that the reason he won this prize was the support he got from an excellent anaesthetic department and the environment of working in a hospital that really nurtures. That wasn't in the newspaper unfortunately. I spoke to his boss and that should have been in the story. It's a pity that it wasn't there. Sometimes you get the impression that the papers are all over something that's a bit negative but they could have been a lot better on that story. It was a good enough story; the pictures were great too. The story behind that is even better.

Mr WILKINSON - Yes.

CHAIR - Thank you very much, Frank. Sorry for the confusion earlier today.

Dr NICKLASON - No worries.

THE WITNESS WITHDREW.

Mr JOHN DOUGLAS KIRWAN, CHIEF EXECUTIVE OFFICER OF TASMANIAN HEALTH ORGANISATION NORTH WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR - Just a reminder, John, too, that the evidence you give to the committee is being recorded on *Hansard* as well and you are covered by parliamentary privilege while you are giving this evidence. Anything you say outside the committee may not be. If you want to give any evidence in camera you can make that request and we can consider that.

We are really after a bit of an update from you. We have heard evidence from the Secretary of Health, Jane Holden and Gavin Austin have also been in earlier and focused on their particular areas. We are particularly interested in the impact of the cuts and the pressures over winter at the LGH. There has been a bit of media coverage over the time when there were some challenges, how you are going with your savings strategies, meeting your targets and your budget and how it looks for the future. If you want to give us a bit of an overview we might come in with questions after that.

Mr KIRWAN - It was a difficult winter. In the four, coming on to five years I have been here, I don't think there has been a winter that hasn't been difficult for different reasons. We are just finishing our evaluation of the winter period and, as I think I have said before to this committee, we look at winter and plan for winter from Easter to the end of September. We define it to the end of the school holidays because that is an important period for us particularly in Launceston. I do not know about the rest of the island, but those two weeks tend to be interesting in themselves. We have got through winter reasonably well, but very difficult. There were high levels of activity, particularly in July where we saw record levels of attendance in the emergency department and probably record levels of sick leave as well, particularly in our nursing staff, so very difficult compounded by our service closures, but despite that we did manage through it.

It is probably reflected in some of our indicators where they have slipped off a bit and I think you have those, but probably not of a significant magnitude. In some areas, particularly when we started to have difficulties meeting our category one elective surgery KPI, we have since taken some preventative action once we knew what this year's budget actually was and we think we now have that fairly well under control.

We didn't close any beds although probably there might have been one or two on occasions due to short staff, but we did use overtime particularly in that July-August period fairly heavily and particularly double shifts. There is a big blip of double shifts particularly in July. We saw over 4 000 presentations in ED, which is an all time record for us in that month. In fact, it was a 10.5 per cent increase in one month, which is pretty hard for us to absorb when you get those sorts of peaks.

If I can move on to the budget, we are now just in the process of finishing finally allocating all of our budgets following a supplementary payment from the department. We are predicting about a $4 million to $5 million deficit for the whole area, roughly half **[2.54.13]**primary health is a par for LGH. Our figures are all trending down in the right direction, so as long as we do not find any additional unfunded commitments. There is a number that have flown into the system that we just weren't aware of and I am sure Jane and Gavin have probably already alluded to those as well. If there is no more

in the system we will bring ourselves as close as possible to a balanced budget, but I would probably have to wait to the half-year review to say that with a bit more confidence.

CHAIR - John, what are the unfunded commitments?

Mr KIRWAN - There is quite a range of unfunded commitment that goes to increases in various EBAs and flow-ons from EBAs that aren't funded, given that the funding nominally is only 2 per cent for that, and if they are greater than that - for example, there is a productivity dividend of 0.5 per cent, but there are other structural changes and changes in classifications. The big potential for us is, for example, in areas like the nursing hours per patient day, but if the ratios show that we have to employ more staff to meet those ratios, we either have to employ more staff or we have to reduce the services.

In the past, for example, some of our closed beds are due to closing medical and surgical beds to meet the nursing hours per patient day, for safe working hours in our emergency department because there was no additional funding available. We are weighting the outcome, particularly in our women's and children's wards, because they don't readily fit the nursing hours per patient day model, which is more easily applied to medical and surgical bed wards and the emergency department.

Also, the government increased our superannuation contribution to pay for [To be confirmed.]TMRF[To be confirmed.], and so we are now paying 12 and a half per cent - we were paying 12.2 or 12.3. We've had a significant increase in council rates. The Launceston City Council has just given us an adjusted rate notice which we're looking at with some degree of interest, and for the LGH alone it shows an increase of 165 per cent.

CHAIR - 165 per cent increase in the rates?

Mr KIRWAN - Yes.

CHAIR - So why is that?

Mr KIRWAN - That is a good question, which we are currently asking.

CHAIR - It's a shame the member for Launceston is not here to assist with that explanation.

Mr KIRWAN - Yes, I was going to make a cheeky comment but I thought I had better not get myself into any more hot water. The big increase, as we see it, is because of our capital works and the revaluation by the valuer general, but they have also changed how much they rate us per that, so it seems to be a bit of a double whammy, which, needless to say is not a pleasant situation.

There are a number of other things that we're unaware of such as the change of the email system mandated by government, and that cost us more. There are some roundabouts though - it looks like we might have some savings in some other areas. But it is the unknown and unfunded commitments that really hurt us. There is a range of those, there is another risk still in the system, too, plus we could really do without another 10 and a half per cent jump, like we had in July. Those sorts of pushes in demand in areas where

we can't offset it, like an ED presentation, like cancer services and others, really limit our ability to change much.

Dr GOODWIN - What is the change to the email system?

Mr KIRWAN - The government has mandated a change to one common system. From all accounts it will be far better, but they are now going to charge us per email account and the additional cost - and the other one is carbon tax, those sorts of increases affect us.

CHAIR - John, with the 10 and a half per cent increase in DEM presentations in July, obviously that would have required a fair bit of overtime and/or double shifts. Jane and Gavin both said they had some provision in their budget in anticipation of that. Did you have a provision for anticipated increase in overtime?

Mr KIRWAN - No, we don't budget quite that way. I think the three areas budget a bit differently. But just to put it in context, the double shifts report for May and June, given May and June puts us into winter, was 50 double shifts in May, 63 in June, and then July was 136. And then in August is was down to 50, September 15, October 21, so you can see it's a large amount, and a lot of that was generated out of ED and ICU. Fortunately in ICU we have since - we're in the middle of it anyway, it just takes time finding, recruiting and placing ICU nurses - filled a number of vacancies, so that compounded it. We're travelling a lot better in ICU, and in ED exactly the same.

We have the physical capacity, as you would probably remember, for 43 bays. We hadn't staffed up to that, which is the cause of criticism of us by the ANF. We now have done that, but it takes time to recruit, particularly given that we weren't in a position to do that until our budget had some degree of certainty for the current financial year.

CHAIR - Okay. As far as elective surgery goes, John, how many cases have been cancelled over the winter period as a result of beds not being available, or the budget cuts, or bed block or maybe an unsuitable bed. Jane gave some figures about cancellations related to bed issues, not patient unfit for surgery or other things like that.

Mr KIRWAN - The figures I have in front of me go to pre-admission by the hospital, post-admission by the hospital, pre-admission by the patient, and post-admission by the patient. If I understand your question it would be pre-admission by the hospital and based on - the biggest number for us is always more non-elective cases overriding the booked admissions. That is not surprising, particularly given we are seeing a gradual increase in ED presentations, but we are also seeing an increase in admissions from ED. That reflects the fact that theatre time is slowly being taken by greater numbers of non-elective cases because the emergency cases take priority. Understanding that we now only operate on four theatres where we used to have seven, and two of the three that are closed were closed quite specifically for budget saving strategies.

Our capacity is really quite limited. One of them was our day procedure theatre that was on the third floor and is now a part of the medical unit, so for capital works reasons it went. We didn't build a day procedure theatre in the new day procedure unit because all the theatres will now be on the fifth floor, both day and major theatres. I am just looking through. Pre-admission to the hospital, on the figures I have, only shows quite limited numbers on beds, because we tend not to book them now.

CHAIR - What about the pre-admission of other patients then. We are talking about people who are fit for surgery - who would have had their surgery except that a bed was not available?

Mr KIRWAN - Not many. I can provide them, but the figures are quite low and I am looking for the winter period. For example, 'no ICU bed', which is often an issue for major cases - in March there were 2, in June there was 1, in July there were 2, in August there were 4. 'No beds pre-admission' using the same sort of period - in March there were 9, April 21, May 4, June 13, July 13, August 24.

CHAIR - It is still a significant number all up then. These are people that have been cancelled when they were fit.

Mr KIRWAN - Yes, but not relative to previous times. I looked at those figures myself and just to put them in broader comparison, if I look at July 2011 versus July 2012, the total amount of pre-admissions that we cancelled was 118 in July 2011, but in July 2012, and understand July was a very difficult month for us, there were only 91. I asked the Department of Surgery, because these numbers seemed counterintuitive to me, and they said they do not book anywhere near as much because they know what the demand is. I would like to claim those figures look better, but it is simply because our booking and our refinement process has become very sharp in the current environment, not surprisingly. When you look to our category 1 and 2 waiting times - how many and where they are - that is where we have had difficulties. We have always not done particularly well in categories 2 and 3, but on occasions we have not met the KPI for category 1, which has caused us some concerns.

Dr GOODWIN - Do you have those figures as well, or do we already have them?

Mr KIRWAN - You should have those. They are publicly available.

Dr GOODWIN - Have we got the latest?

CHAIR - I think we have only got them up to the end of June.

Mr KIRWAN - We can provide the later ones.

Dr GOODWIN - John, how many beds are closed now?

Mr KIRWAN - There is a definition issue on beds closed. I probably need to define how we have done them. There are various questions on notice, including probably one of yours.

Dr GOODWIN - Yes, I have a few on notice.

Mr KIRWAN - We have answered the questions on the number of beds closed that are physically built, even though the beds may not actually be on site now. We currently have 64 beds that are closed but could theoretically be opened. Would we open those beds? No, because some of those are, for example, because of our changed models of care in areas like paediatric. We don't need a 28-bed paediatric ward. It's down to 17 staff there. It does flex up and it has flexed up. It was a busy area, particularly when we

had a respiratory outbreak in our neonatal intensive care unit in the middle of winter. We had to quarantine our neonatal intensive care unit and only admit some of the patients on the paediatric ward and special them, so we went up. The closed beds we have now, due to budget reasons, is substantially the 32 beds on our closed ward 4D, plus some eight surgical beds that will still be closed. We are opening 12. We have opened eight since June in surgery and we will open another four. I am doing the maths in my head. I think that adds up.

Dr GOODWIN - They haven't needed to get any out of storage?

Mr KIRWAN - No, we moved some of those back.

Dr GOODWIN - Okay.

CHAIR - We have the waiting list and the median waiting times with the categories until end 30 September, in very small print. What we did have up until the end of June was the speciality clinics. We have it by category but not by breakdown of area, of surgery, speciality area.

Mr KIRWAN - Are we looking for the waiting times for surgery or for outpatients?

CHAIR - We have outpatients up to 30 June and we've got the waiting times for surgery until 1 September. Just in the categories.

Mr KIRWAN - The one in the small print - you see the deterioration in some of those median times. You see the growth in our waiting lists as well. I should say that the current commonwealth program, out of the 325 million which we signed up to, we have in operation which goes to long-wait patients. That is advancing and seems to be working well where it is a relatively small number of the long-wait patients that will be addressed within defined areas.

CHAIR - What areas of the LGH do they impact on?

Mr KIRWAN - I have to check on that as I don't have that before me. Ophthalmology was a big one. There was some orthopaedics and there were a few others. Ophthalmology was the bigger one for us because that is where one of our longer waiting lists is.

CHAIR - I know in the north-west, one of the challenges for ophthalmology, which seems to be a problem everywhere around the state, is that they have only one surgeon up there. When he is not operating, he is not operating. Is that the same sort of thing in the north or are there other challenges there?

Mr KIRWAN - Within ophthalmology?

CHAIR - Yes.

Mr KIRWAN - No. We don't have that problem. We arguably have the reverse problem.

CHAIR - Send one to us then.

Mr KIRWAN - I was about to say the difference is they are not our doctors. We contract the eye hospital. A long time ago they set themselves up as a nice business in Charles Street, just down the road, and they do all the public and private work there. We contract with them and we are just finishing the negotiations of the current contract so I need to be careful what I say. They have a capacity that we don't have because they have a critical mass in that area. They are well serviced and they are a training hospital and they also provide us with our out-of-hours emergency cover. It works well for us.

Dr GOODWIN - In terms of emergency department presentations, we heard from Mr Daly that there has been some improvement in that area because of the new GP super clinics. Is that something you have seen?

Mr KIRWAN - Not in Launceston. There is no such thing as a GP super clinic. I think the nearest one to us is in Devonport.

CHAIR - That is not open after hours.

Mr KIRWAN - Then it may not be super yet. It may be a standard clinic.

Dr GOODWIN - It is pretty much status quo as far as that is concerned?

Mr KIRWAN - If I describe our ED activity, category one, the most urgent, we see at 100 per cent of the time. Sometimes you might see the figures fluctuate because there is a coding problem and the trouble with what is relatively small numbers, is it only takes one or two miscodes to suddenly throw them around but category one is where we prioritise. Obviously they are the most important so we meet that 100 per cent every time and if we don't, it is not because we have not met it, it is normally a coding issue or a key-stroke issue.

Category five we meet and categories two, three and four we are improving our performance. Where we are struggling is our access block and there is a range of reasons for that including the number of in-patient beds we closed but we are slowly addressing that. As the emergency department itself properly opens up with its new models of care, as the acute medical unit fully opens up with its new models of care and we are recruiting into both of those areas, you will see an increase in our FTEs, neither of which we opened up as we probably would have intended to do because we used those funds to fund what was our then deficit last year. We delayed the opening in those areas. That was a savings strategy because that money, using non-accounting terms, was new money so it had not been spent. It was easier not to spend it and to put it into savings because with the current level of activity we realised we could not do that forever. We are now in the processs of opening the ED and the AMU fully. The new models of care that come with both the emergency department and the acute medical unit should see, and we have put a whole lot of plans in place, significant improvements in a number of those indicators. Our only concern would be access block and if we have closed too many beds. We are working that through at the moment.

CHAIR - John, with regard to the savings strategies it sounds like you are going to come in about $4 million over budget. What other savings strategies are you going to employ to get within the budget. That is an expectation that you will be in budget, particularly this financial year, under the THO model.

Mr KIRWAN - Under the new legislation, the governing councils do not get a choice. It has been truncated a little bit for a range of internal reasons which I do not know whether Matthew explained or not. A new accounting system, changing over to activity based funding, has made the first couple of months quite messy. Now we have had two clear months to get all the mapping right and work out where everything has gone and we think it is stable enough to make some calls. We are structured a bit differently to those two other areas. We still run the LGH and primary health quite separately, albeit they are integrated at the management level, and they are integrated in other areas like patient care and allied health and areas like that, and professional responsibility, and quality and safety but we still run them as separate budget items. Primary health north, particularly with our 24/7 sites, is carrying a structural deficit of between $3-5 million but they are identifying quite a number of savings which are mainly one-off so although we might limp across the line this year as we did last year, they are recurrent and we need to be honest about that. With LGH we put in 51 savings strategies, some we achieved some we over achieved. There was a range of different strategies under four broad headings.

We are still progressing all of those that are recurrent and they are bearing fruit, understanding that we didn't start to put our strategies in place until December/January, so we are now seeing a full year effect which is nice. Nice for me, probably not nice for some of the staff and patients. There was a number of longer-term strategies, such as privatising the laundry, and others that are coming to the fore, and come 1 December the laundry is transferred to a private operator. There is a range of those that are coming together quite well.

CHAIR - Have you any other additional strategies? The north west and south have given us a few ideas of other things they are progressing. Some of them that have been probably on track but some of the newer things to keep on track?

Mr KIRWAN - Keeping going the existing strategies we had in place and driving those hard. Keeping the current restraints. Increasing our revenue as and when we can. We have always been relatively successful in doing that in broad terms. We have some additional things. For example, with the opening of our parking area we have introduced parking fees to everyone, and that is everyone from the CEO down, so that is generating some additional income. Those are new things to what we didn't have last year because there were timing issues for us.

CHAIR - What other ways of maximising your revenue besides charging parking fees?

Mr KIRWAN - In respect to our area it means benchmarking with other hospitals. There are areas that we have not seen or don't seem to be doing as well. In relative terms we were always going okay, but we know some of the areas like prosthetics and particularly when we are looking at the nationally efficient pricing, there areas where we have some inefficiencies. What I call structural, technical inefficiencies. If that is because we are paying too much for something, what we have done is gone back to the contracts or to the suppliers. Some of those have required some of our senior surgeons to specifically go through every invoice when we have said no, or in some instances say can you please stop using this because this cost this; this is the same as this; can you use this; this is cheaper; and this brings us within the nationally efficient price and the DHE price. It is quite cumbersome but it is working.

Dr GOODWIN - Why are there issues with ambulance ramping growing during the winter period.

Mr KIRWAN - We are a hospital that does not support ramping. I do not think any hospital does so it is not meant to be a parsimonious comment. We do not support it and we try not to use it and we do not use it as a tool to manage our demand. Just the same as we don't support going over census on our wards. The policy of this hospital and it pre - dates me, and it is one that I strongly support, is the best place for patients who require emergency care and potentially follow-up care if we cannot get them into the hospital beds, is still the emergency department because it is the area that is staffed and equipped to deal with that. Particularly in the new emergency department. In the old emergency department I may have had to mumble a bit but we try not to ramp. We look at it very closely. It only occurs hopefully in the peak periods of demand so we are looking at it. The ramping figures are improving significantly. I might have them somewhere. Understanding that we didn't collect ramping [figures]. We are relatively new to the ramping collection figures which makes it a bit difficult to see whether we had a previous problem before or it was absorbed. If I go to the peak of ramping for us in the numbers of ambulances ramped was July at 120, August at 114, September is down to 54 and the preceding months, April, May and June, were around the 50 to low 70s.

Dr GOODWIN - What does that measure - the hours or the number?

Mr KIRWAN - That is the number. The hours are separate. The hours ramped in June were 49.85, July 80.35, August 96.93, September down to 40.02.

CHAIR - How does that compare with last winter?

Mr KIRWAN - We weren't collecting the data. We collect the data as based on 15 minutes the same as the Royal, the international standard in this area. A lot of the other states use 30 minutes which half of me is tempted to say I wonder what would happen if I turned it to 30 minutes. It might go down significantly. One would hope it would. There is not a national standard and I suspect we should have one. However, having said it, we do not like ramping and will try and avoid it. Particularly with the ambulance service here, unless it has changed, was always the busiest on the island and we do not want them waiting on our apron when they should be doing someone else.

CHAIR - John, as far as that goes, the DEM time targets, the federal government, as far as this incentive funding you get. When does that come into play?

Mr KIRWAN - I think it is in play now but I would have to check. We have not paid much attention to that because we thought we would be probably struggling until we get a few other things right.

CHAIR - My understanding is that if you do not meet the DEM time targets, I think it is four hours admitted, transferred or home or discharged, then you do not get this additional funding. The concern was that ramping would increase as a result of that because the clock doesn't start until they get through the doors.

Mr KIRWAN - We would not do that. I would probably get run out of town by our clinicians, let alone our ambulance officers. Even if that goes to not meeting [targets] that would not be a policy we would put in place. One of the nice things is that Launceston is too small for us to play games with ambulance officers, some of whom are our former nurses. Some of whom are married to our own staff. It doesn't work. I do not want open aggression between us and the ambulance officers on the apron. Life is hard enough and under enough stress in a busy emergency department on a busy Saturday night, to put our finger in any of that to-ing and fro -ing.

CHAIR - John, how would you assess staff morale across the whole of your facility?

Mr KIRWAN - If you had asked me in the middle of July I would have said in tears. I think that people, particularly as we have gone back to open some of the new services that were coming and that we delayed. One of the surgeons said to me this morning it is nice to know I can book some surgery and I know I will pretty well get to do it. I think it is positive and she commented that she noticed the attitude of the ward staff that the pressures have come off a little bit. Having said that, our ward occupancy levels in our major surgical and medical wards is still very close to 100 per cent so that place is still full, still busy. The staff has done a magnificent job. We have kept the services going, we have kept the beds open and even when we were starting to run short of staff, the staff have stepped up and done overtime and double shifts rather than closing beds because they know what that means. They have to be given a lot of credit for that. They get frustrated when they see a whole ward closed but that ward has been used to move our medical oncology patients while we do up that part of the Holman Clinic so it is not as if it is used and barricaded up. It is being used to hasten the changes to the Holman Clinic which otherwise would have been more difficult. It is a mixed blessing in that respect.

CHAIR - Do any of the members have any other questions? Is there anything else you want to say, John, in closing or do you think you have said enough?

Mr KIRWAN - No, I think we have covered most of the areas. I suppose we think we haven't got our budget under control. We've still got to close that last gap. We're working hard on that. A $4-5 million deficit is a lot better look than the $24-25 million we were looking at at the end of June. We are aggressively chasing a number of the commonwealth funds and other and that does allow us, particularly some of the elective surgery dollars to help us fund FTEs, to re-open beds and do more surgery in those areas so we are using those funds quite judiciously.

CHAIR - Thanks for your time. We appreciate that. We will talk you another time no doubt.

Mr KIRWAN - Thank you, committee.

THE WITNESS WITHDREW.

Ms NEROLI ELLIS, SECRETARY, AUSTRALIAN NURSING FEDERATION, WAS RECALLED AND EXAMINED BY TELECONFERENCE.

Mr JAMES LLOYD, **Ms KIM FORD** AND **Mr ANDREW OSTLER**, AUSTRALIAN NURSING FEDERATION, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR - Your colleagues are across the table.

Ms ELLIS - Excellent.

CHAIR - You know whom you've got here, do you? Margaret, James and Andrew.

Ms FORD - Kim I go by.

CHAIR - Sorry. Kim.

For the benefit for the other members of your team, Neroli, I will just explain how the committee system works here. Everything that you say is being recorded on *Hansard*. I don't think the media are back again but they might come back. You are covered by parliamentary privilege while you speak before the committee but if you repeat things outside you may not be. You need to keep that in mind. If there is anything you wanted to say in confidence then you can make that request and we can consider that. It is for anything you want kept confidential that you would want to do that.

We are really interested in looking at the impact of the health cuts beyond our last series of hearings before winter when the cuts were just starting to take effect. Particularly at the LGH, for example, the cuts were not made initially; they were a bit later in the year and [we want to look at] how things have been over the winter break and also looking at the impact on nurses in various areas. I don't know who wants to speak first; Neroli, do you want to lead in?

Ms ELLIS - Thanks, yes.

Firstly, I appreciate this opportunity to provide further feedback on these extra budget cuts and also to apologise about the teleconference but I will try to make sure that you will get a lot of feedback from our reps. We thought we might break this down into three sections to try to get a process and framework to our submissions.

The first is the effects on patient care and service cuts. The second is the access block and looking at what's really happening now as far as how we are coping, and the third is the workforce issue.

We'll start off with the service cuts and the effects on patient care. The first issue we want to raise is around the service cuts and what has been happening in regard to where the cuts have been hitting the hardest and had the greatest effects on patient access and care. We were obviously thinking about elective surgery but it's not just elective surgery and the acute system. It's all having quite a significant flow-on to mental health and CHAPS and other services outside the acute hospitals. I will pass over to Kim who is

going to give an overview on clinics, appointments, elective surgery and where we are up to now and what's really happening in our hospital system around acute surgery. I know the members will be keen to hear the feedback from all of our reps and I will open up a space to allow them to give that feedback.

CHAIR - Thanks, Neroli. Can you tell us what your background is to start with?

Ms FORD - My role at the moment is as the nursing manager of the outpatient clinics. I've been in that role for three years.

CHAIR - At the Royal.

Mr FORD - At the Royal. I'm well acquainted with the waiting list for clinics, which is actually the hidden waiting list. People wait years to see someone in clinics and then they go on the elective surgery waiting list and they wait another number of years till they actually receive their treatment. I read in the paper about Graeme Alexander speaking about a patient he had. That lady would have waited two or three years to be seen before being put on the elective surgery waiting list and then waited however long for surgery.

Just recently the neurosurgery outpatient wait lists have been in the media as well. To date, neurosurgery has 1 328 people waiting for an outpatient appointment before they are even considered for surgery or receive any treatment. We have a category system similar to the elective surgery waiting lists. Category 1 should be seen within 30 days because it's considered to be not life-threatening but life-altering. Category 2 is a 90-day time limit, and category 3 is 365 days. There are 516 category 1 neurosurgery patients and the longest wait is 1 086 days, so someone has been on that category 1 list for 1 086 days waiting to be seen.

The gastroenterology and endoscopy waiting list is another issue that's very much in the forefront. We have 1 156 people waiting for a gastroenterology appointment, 372 category 1 people waiting up to 400 days. It's been reported to me that someone waited that length of time, then had to have an endoscopy, and had to wait again. By the time they had the endoscopy, they had inoperable bowel cancer. People are waiting on these lists with significant health issues.

In orthopaedics there's 1 137 waiting on category 3, which is the lady with the hip replacement. There's about 243 of those. With orthopaedics, if you're a fracture and a category 1 you are seen, everything else is basically considered non urgent. They are waiting 600 days to be seen. There are other things we can do in the meantime. They're not seen by physiotherapists and the longer these people wait, the sicker they get and the more complex their comorbidities. By the time they're ready for their surgery they may not be well enough, and in the meantime they're losing function and experiencing pain et cetera. That is the hidden waiting list, before they get onto the list for surgery.

Andrew has some figures about elective surgery, year to date - how many cases have been cancelled and what the effect of the bed closures has been.

Mr OSTLER - I am the acting nurse unit manager of neurosurgery, but usually a clinical nurse on the floor, a coordinator. To date, for the calendar year, 'bookings postponed by

hospital - pre-admission', are 1 327. That is broken down - the big numbers are overriding emergency, 414. If you have waiting list booked beds for people who know they are coming in, but you have traumas or someone arrives with a big bleed, then the lists are bumped. There are 'other no-beds' - no-beds would be 173 to date. I make the point early on that the hospital has funded beds and we're told to live within our means with beds but we constantly open the beds to get some surgery on the waiting list done. The wait would be bigger for cancellations if we didn't often open up the beds.

CHAIR - So you open the beds for elective cases but not emergency cases?

Mr OSTLER - No. Neurosurgery runs on 20 beds, and has from about March this year, not the 24 we had. We put a list forward. There is a list made up for the week from Monday to Friday and then we have a number of traumas - for instance, I think about a week ago we might have had approximately 19 big cases through, some elective but mainly acute. When we look at bed management we meet each day and say, 'We've got four to do on the elective list. We have these acute traumas we have do. We've only got so much theatre time and so many beds', so we open beds. The bed management and the NUMS open beds. The opening of beds allows some more elective surgery to be done. I can give you for the month July, we run at 20 beds but on 22 days of the 31 days, we opened between one to three extra beds on neurosurgery and a lot of this is to cater for elective surgery.

Mr OSTLER - I also want to add that EDU also competes for those beds because of the blocks. The need is great. As well as using them for surgery, EDU wants to use that space as well.

Ms FORD - On the neuro ward?

Mr LLOYD - On any ward.

Ms FORD - All wards are opening beds like neurosurgery. They are all having what they call flex beds. Temporary beds. One to four beds per ward that do not always come with staffing.

Mr OSTLER - That is one thing. August we had six days only where we opened one to three beds. We only had three beds. Normally it is four. One was being involved with a redevelopment for a short time. That was a bad month for us in many other ways because you had so many acute admissions. We had high dependency patients down the corridor. We could not fit, open, more beds, because our staff were tied up with high dependency patients. That skews those number as well.

Dr GOODWIN - Is that related to the winter period or just happened?

Mr OSTLER - Some of the things on these stats do relate to the winter period. This is sick leave and overtime and we will be covering that later on. In those days that we do keep beds open, or open new beds, we do not necessarily have the staff. More often than not we don't. In the month of August we have all the nurse unit managers in service, so we kept a really close eye on the stats and were accurate. We had 36 shifts that we were down a full person. That is four or five patients that have not been allocated.

In any normal year you can fill those 36 shifts with double shifts or the pool. In this case 24 times during the month we did not have anyone. No-one would do a double. People refused. They could not do it. They were too tired. They were getting run down. They were physically and mentally tired. They could not face coming back or staying for a double shift. That is the first time in my memory of 30 years at the Royal that that has happened.

Mr LLOYD - I am James Lloyd. I am the NUM for casual pool and after-hours manager. The thing about the winter busy period is that is very blurred now. We did have a peak of activity and the staffing problems there have been, but it is blurred right up to *[inaudible]*. Last weekend was really quiet but for the three weekends before that it was just [*inaudible*] in the hospital. Is the winter period everyone talks about the peak, it blurs that right up to someone saying they have to get away from it. Winter is almost nine months long in a sense.

Dr GOODWIN - Is it weather related or is it activity related.

Mr LLOYD - It is almost consistent for a nine month. It is busy, busy. It may go to summer as we do a little bit of that surgery and we close some wards and maybe it quietens down a little. Even in the middle of summer it can be very foul especially when people drive their cars too fast and stuff like that.

Ms FORD - And drink too much.

Mr OSTLER - James is right. It used to be more defined but now it seems to be tough for the bulk of the year. It is really tough and you are working down in hours or nursing hours. Everyone is tired. The doctors are tired, we are tired, the multi-disciplinary team members are tired. There is so much pressure now generally to get patients in, process them, get them out. Often getting them out before you ever normally would, with limited resources in the community but you have so much pressure on getting more people in and through.

Ms FORD - The other compounding factor is the number of vacancies that are nursing vacancies and nursing positions we have lost. We are using what used to be a healthy casual pool, it still is healthy, but we are using those numbers to fill roster gaps so that when the day arrives and there are people off sick the casuals are already being used to fill roster gaps. There are not the people there that can get called in and do them so that people are having to do more double shifts which adds to tiredness, sick leave, et cetera, so we are chasing our tail.

Mr LLOYD - I worked out on any average day about 55 FTEs or casuals are used in the hospital and about 33 of those are booked at least four weeks to two months in advance. As Kim says, when you come to day there's no-one left so there's overtime and double shifts.

CHAIR - We were told about the ProAct rostering system, is that going to assist?

Mr LLOYD - Not really. ProAct is more of a database to allow us to put in data so we can see what's going on. It's not going to make staffing better; staffing is a completely

different issue. ProAct is a fantastic tool for finding out information and interrogating what's going on and getting data, but it's not going to help -

CHAIR - We were told it was going to be used in a more forward-looking rostering system so it can interact with expectations as well as the current situation.

Mr LLOYD - Usually the rosters are only done a month in advance so you can see what's going on in advance, but it's not designed to go six months in advance.

Ms FORD - You can't predict activity and that's what drives the need for the workforce. I can't look at the roster -

Ms ELLIS - If we go back to the effects from elective surgery and then come back to the workforce issues. I think Kim mentioned one of the examples of electives now becoming emergency. One of our concerns is there's no data to reflect the impact of those sitting on elective surgery waiting lists who are now turning up in our emergency department with complications and needing emergency surgery. There was a recent case at the Launceston General Hospital where a young, single mother on the waiting list ended up with pancreatitis in the Intensive Care Unit, should would never have happened if she had been operated on in [*inaudible*] 30 days with category 1. We can't get that data. I don't know whether it is available through this committee, but it doesn't seem to be recorded anywhere as to the real impact of elective turning into emergency or ending up in the emergency department with an emergency admission.

I will finish off some of the issues around the service delivery changes and what's happened. I will go to CHAPS, the Child Health and Parenting Service, where we now have the data from the winter period in the last three months. There were 580 family appointments cancelled because they haven't replaced the family child health nurses and with the budget cuts they're putting a ban on using casuals, so they are now cancelling appointments. These are new mums who are desperately needing the support of the family child health nurse in their local environment. They often don't go to the GP if their appointments are cancelled.

Dr GOODWIN - Neroli, can I just clarify something on that. Are those appointments regular appointments that are being cancelled rather than new mums ringing up and specifically requesting help?

Ms ELLIS - Both. There is a schedule of appointments, so a new mum comes in at four weeks and eight weeks - I don't know the exact schedule - there is a schedule of appointments following birth. Those are the sorts of appointments that are being cancelled. They are appointments the mums have made themselves to come in and have their regular baby check. There may also be post-natal counselling for themselves. The other effect on the family child health system is linked to child protection, working as a team, is their professional development significantly dropped. There are now a few workers compensations claims that have come through recently and there are 30 electronic incident reports that have been done over the last two months which are near-misses or clear concerns from a patient perspective that family child health nurses have completed. CHAPS is a real concern for us going forward.

We note there are no school nurses left in Tasmania with the budget cuts. Basically the last child nurse position was cut due to the budget cuts, so we are the only state now with no school nurses doing the regular checks that other states have access to.

Mental health is another key issue that has had severe impacts in regard to cancellation of appointments. The amalgamation of PICU, the psychiatric intensive care unit, with the Department of Psychiatric Medicine is impacting across the state now. PICU - the Psychiatric Intensive Care Unit - was purpose-built for clients with violent tendencies who needed to be appropriately secured but didn't need to go to Wilfred Lopes. We used to transfer patients from the Spencer Clinic in the north-west and north to PICU but we've had a situation in the north-west at the clinic where 24 assaults over the last year have occurred on nurses by three particular patients. Normally these mental health clients would be referred and transferred down to PICU for the appropriate treatment and environment but, unfortunately, PICU is now closed and the north-west and north of the state cannot get admission into DPM, so they have to handle those types of clients themselves, which is escalating into violence against nurses, particularly in the north-west by these three or four clients.

Dr GOODWIN - Those patients you are referring to, what sort of ward are they on? Where are they on the north-west coast?

Ms ELLIS - It's called the Spencer Unit, which is an acute-care psychiatric and mental health unit. It's the same as Northside in Launceston. Spencer is attached to the North West Regional Hospital in Burnie. It's a 20-bed unit but it's not purpose-built to cope with someone who needs a different environment and a secure environment.

Dr GOODWIN - So basically we've lost that intermediate step between those units and the Wilfred Lopes, the PICU?

Ms ELLIS - That's correct, and we've lost bed numbers and capacity in mental health, which also has a flow-on effect for our emergency department. People are waiting for admission and they're having a longer length of stay in emergency. Mental health clients are often the ones having to wait up to three days - it was reported to us - in the emergency department for a bed. That is having a severe impact on the emergency department. Some of those patients are now being admitted to general wards at the Royal, which is totally inappropriate but there's nowhere else for them to go.

We also note that in the lower House the Mental Health Bill has just passed, which is of extreme concern to us. The change in criteria to the approved psychiatric nurse, to remove the requirement to have a mental health qualification - we believe this is due to budget cuts. Generally-trained nurses now will have the ability to order restraint and seclusion on clients. We will be speaking to upper House members when they give consideration to that Mental Health Bill.

CHAIR - It's on our notice paper already.

Mr WILKINSON - Getting back to the staff, Neroli, I understand with the waiting periods you have 1 328 people waiting for neurosurgery, 1 086 days waiting to be seen. There are 1 156 waiting to be seen on gastroenterology and 1 137 waiting to be seen in

orthopaedics. Do I take it those people aren't into the system as yet so far as the statistics the government gives us?

Ms ELLIS - That's correct. Those who are waiting for appointments and outpatients are not on the waiting list. They haven't been by a specialist who can refer them to the waiting list. This is the hidden data. These are examples from the Royal but it is right across the state that these sorts of numbers are waiting to get onto the waiting list. There is a lot of spin in the data with some things that carry right across the board.

Mr WILKINSON - I think those figures are important because the figures we hear of are once they see a doctor and then are waiting for surgery. What you've got is these people waiting three years before they're even seen, let alone waiting for surgery. It's a bit like school - you've got to book in at birth.

Ms ELLIS - That's correct. This is just delaying the inevitable. They need and have to have their surgery so it's a false economy to be pushing them out further. They're becoming more complex, requiring more analgesia, physiotherapy and GP demand during this period of wait. Unfortunately, the federal government package is not going to address this to our satisfaction. It's a very minimal figure coming through from the federal government money designed for elective surgery, so we will not see that have any real effort to the Tasmanian public, unfortunately.

CHAIR - To what date are those figures?

Ms FORD - Yesterday.

CHAIR - We have figures up to 30 June that say that statewide 8 405 people are waiting at specialty clinics to be seen. Outpatient waiting list for specialty clinics, that is the same thing that you are talking about. The people waiting in the neurosurgical clinic at the Royal, according to this sheet, at 21 June 2012, were 567.

Ms FORD - That wasn't the elective surgery waiting list, that was -

CHAIR - This is the outpatient waiting list for surgery specialty clinics.

Ms ELLIS - In neurosurg?

CHAIR - In neurosurgical clinics at the Royal.

Ms FORD - I dispute that data.

CHAIR - This came from the department.

Ms FORD - I'd dispute that data.

Mr OSTLER - Certainly I've seen, because I was interested, there was an article on neurosurg and I looked at the data two weeks ago and it bore no relevance to what I saw on the screen about the numbers waiting to get into clinics. Even the quoted elective surgery numbers actually on the elective surgery was out by about 50 I think, and even one of my consultants quoted the right number to me on that day and he knew the data

just from memory. I'm not sure where they're getting their figures from. It is a bit unusual.

CHAIR - I'm interested in the figures because waiting list data as at 30 November 2012 -

Ms FORD - We are not there yet.

Mr WILKINSON - We haven't got there yet.

CHAIR - Yes. The number of people waiting on surgical outpatients lists, neurosurgical clinic and categories1, 2 and 3, are separated out at 851. I'm not really sure what has happened. I will have to clarify some of that but the figures aren't quite the same either way.

Mr ELLSI - Kim, I am just wondering where the most accurate data source is - upper House members may need to get the accurate report in.

Ms FORD - I have taken these numbers from IPM, which is the patient administration system where we keep all the waiting list entries so it's the source of truth. The week after next I am going to spend some time with Simon Foster from the Business Intelligence unit because Simon would have got the neurosurgery figures that were different to the ones that we had, to look at how he is getting his figures and how it differs. He goes in the back end and pulls bits out. I'm not quite sure how he arrives at his figures but they were quite different from the figures that we were able to get.

Mr OSTLER - And on that day they were very different to the ones quoted by the surgeons that I spoke to about what those numbers were like. They were completely inaccurate. The accurate figure was the one I saw on the screen on the same database.

Dr GOODWIN - So you think there could be some sort of filtering process?

Ms FORD - I'm not sure how they are sourcing the data, what fields they are using to source the data, what they are including and what they are not including.

Dr GOODWIN - Is it all in the same system though?

Ms FORD - Yes, it is all in the same system but they extract the data according to certain fields so whether they are not using the right descriptors or what I am not sure. I'm going to sit down with Simon the week after next and work through what he's doing at the back end to get that data to see why the discrepancies are there.

Mr OSTLER - That data you think is completely accurate though.

CHAIR - We will ask the department about the data on that as opposed to futuristics.

Ms ELLIS - Is it okay if I move on?

Mr OSTLER - Can I just make one more point, Neroli, because you asked me about the postponed cases. There are also post-admission postponements for the year and as of a

few days ago that was 509. So the total cancelled cases, by hospitals, this calendar year, is 1 836.

CHAIR - That's for all causes.

Mr OSTLER - That's for the Royal, for all reasons.

Ms FORD - Hospital-initiated.

Mr OSTLER - Yes, hospital-initiated because patients initiate them too of course, but that is just related to perhaps we can say to beds and pressures and -

CHAIR - Emergency cases.

Mr OSTLER - Particularly emergency cases. On neurosurgery too, I can't remember whether I mentioned it but 133 cases were cancelled last year but we are already over 200 this year so that's quite a jump in cancellations for just neurosurgery. Obviously I know that place best. I've gone through every patient that was cancelled and about 60 per cent are from over-riding emergencies because we do not have the theatre time to do everything. We have had sessions cut. We now have surgeons saying, 'What are we meant to do?'. We've got these lists going up and up and up and we can't get theatre time, we can't get beds.

Ms FORD - When they do get theatre time for emergency surgery, it's usually at clinic times so clinics get cancelled. The day of clinic we've got three cases from the weekend and we need to do them - cancel the day's clinic.

Mr LLOYD - Further to that I have a third hat as well. Often I am also the day bed manager as well. Prior to the big cuts last year every day we would have to get in approximately between 20 to 28 people into the hospital to have their surgery. They come in on the day, go to surgery. After all the bed closures and cuts that went back to about 10 to 18 and it has been consistent over that time. There is a third less people that we are getting through the doors to do that. That is reflective on what Andrew has been talking about less theatre time. Those numbers are not talked about.

Mr OSTLER - I have jotted a few things down because we are still covering waiting lists aren't we?

CHAIR - Yes.

Mr OSTLER - In discussion with my colleagues, including the surgeons, we do see it like an iceberg and we are chipping away at the top and doing a very good job when we can get people into hospital. Most of it you can't see. Most of it is hidden away, and we have known this for a long time. I need to know those things at the moment because we are looking at future planning for the new unit in the new wing and what is our need for capacity of beds. When you look at this you go, oh my God, how are we running on 16? We actually have 35 patients in the hospital at times. How are we meant to be coping with 16? If I ran neurosurgery at 16 beds I really wouldn't get any elective surgery done if we truly followed that course. That is a fairly common thought for my colleagues and me.

Ms FORD - And for the other specialities with the same sorts of issues.

Ms OSTLER - The pressures are on people like liaison nurses. There is a liaison nurse who is really your central focus person for the community. People on the waiting list, people often who are trying to get into one of Kim's clinics. They know they want to see a surgeon and then GPs. They all ring one office and the liaison nurse's key role is to look at the waiting lists and she knows them intimately. She knows people on that list like friends because they call her so often. There are two other clerical people in that room who answer the phone as well when she is not there. They say they are getting up to 100 phone calls on a bad day from people on that type of list, the real list. They are rarely aggressive, but begging to see someone to get into hospital to have an operation. There are all kinds of pressures on certain people who deal with these people. One of the consultants only yesterday when he heard I was coming here, asked me if I could make the point that he is sick of getting ministerials that say why can't they take this patient to theatre. He said they know why we can't take them to theatre. We do not have the theatre time and we do not have the beds. He was quite animated and passionate.

Mr LLOYD - Also just remember that ED can want these beds as well.

Ms FORD - And get priority.

Mr LLOYD - Sometimes there will be a priority and it is elective surgery.

Ms FORD - I am regularly dealing with ministerials too.

Mr OSTLER - It is weighing us down a bit now too so it is affecting the service because we are having to spend so much time dealing with it.

CHAIR - You want the Libs to stop sending you stuff.

Laughter.

Ms ELLIS - The other reason is that we would like to have this accurate, honest information for the public to access on the Internet to know exactly what the waiting lists are for each of their categories and to have other options available. *Inaudible* At the moment one of the nurses has been told she is not allowed to tell them the real time and she is not allowed to tell them any other options - for example, funding it in private and approximate prices. I think that many people would choose other options if they knew all the options but there is no data that is available for people waiting at home.

Can we move onto access and what is happening now in staffing and what is happening in our emergency departments? Also we could touch on the fact that we have many beautifully, newly commissioned areas that we are just not using because we have no funding for it. We have empty beds that we are not using and acute care at the Launceston General is only half full because we haven't got enough funding, yet we've got infrastructure. It is a bit like *Yes Minister* - no funding to open up the services despite the fact there is a real demand out there for those services. I will just open up with the emergency department - James, I think you were going to feedback about what's happening at the emergency department in access block.

Mr LLOYD - Yes, with the bed closures obviously it is finding it harder and harder to get people in and it is not unusual if you come in in the morning at 7.30 in the morning and there are 12 people waiting in ED for beds and there are usually medical patients, some are surgical patients.

We talked about pysch patients; it is not uncommon for a psych patient to sit for a further 24 hours in ED if not longer because usually the psych services fill up during the daytime and then 5 p.m. comes around and there are no beds for them. They have to sit in ED all night and wait.

CHAIR - It is hardly the ideal location.

Mr LLOYD - Yes, exactly. This puts ED under unbearable pressure because they are the butt of what's going on because they've got ambulances coming in. We as bed managers don't have any beds to give them and they fill up the outpatients ward waiting for beds or there are scarce beds. That creates a whole stress environment down there. In general, in the hospital people aren't happy. The morale is low, it's not great because of these ongoing issues.

I think Erin was just talking about AHPRA, which is the assessment planning and it is a concept unit where people come through ED and if they are a medical patient they will go into a unit and they will spend 24 hours there getting worked on to either go to a ward or go home. Prior to the cuts there used to be 16 beds, when the cuts came we went down to 10 beds. They got this funding from the commonwealth to build this fantastic new unit, which they did, next to the ED, which is a 26 bed -

CHAIR - We had a look at it when we were there.

Mr LLOYD - You've seen it. I was going to say you guys should come and have a look. It's beautiful but only 10 beds are being used. Sixteen beds, I will say 16 beds for *Hansard*, are not being used. Every once in a while when everything implodes, we will open up some beds from ED and staff it but that is like a few days here and a few days there but sixteen beds are not being used. This money was spent from the commonwealth and they are not being used.

CHAIR - Is that because there is not the staff for them?

Mr LLOYD - Yes. There is no money for the staff and the hospital doesn't have any money to open up and these beds are sitting there, these spaces are sitting there. It's almost a tragedy. We had this brilliant concept, this brilliant idea, that would help to relieve the pressure on ED and so forth and it's just sitting there and not being used. It's crazy. It does my head in.

Ms FORD - Along similar lines the outpatients are moving to the Wellington clinics to increase our capacity and to future-proof. We're not allowed to employ more staff so we're not going to be able to use all the rooms. It has to be a cost-neutral exercise.

Mr LLOYD - We have this dichotomy of all this money coming in from one end, these buckets of money, which is fantastic, we want it but at the other end we have no money to employ the staff. It's different budgets and it's crazy.

CHAIR - The capital works are funded by the commonwealth and the recurrent staffing is funded by the state.

Mr LLOYD - Yes. This funding for this immaculate ward was actually separate from the Wilkie money, so this came in a year or so ago. It's separate money but there are 16 not being used.

CHAIR - It's all right for the commonwealth to fund beds and say the state can worry about the staffing.

Mr LLOYD - Yes, I know. So they are just sitting there, we have wasted space.

Ms ELLIS - There is a problem with funding these.

Ms FORD - Sorry, Neroli, that will be a problem with the new development as well. There will be capacity but not staffing to actually run it.

CHAIR - What's the solution?

Mr LLOYD - Money for staffing.

CHAIR - Where from?

Ms ELLIS - With states probably *inaudible* is commonwealth.

CHAIR - That's right.

Mr LLOYD - I suppose it has to come from the state but if you could fund these beds it would relieve the pressure on ED, it would relieve the pressure on the wards so we are not filling up beds for elective surgery from ED.

CHAIR - I'm not trying to put words in your mouth - would that create efficiencies or how would it make it work? If there was additional funding for staff in those areas, how would that reduce your overall costs, or would it? Or wouldn't it? Is it just that you simply need more money?

Ms ELLIS - It actually would meet the needs to ensure that we could provide safe care. That's the bottom line now. We believe there are patients at risk now or cases waiting in emergency or not even getting into emergency are clearly at risk and certainly anecdotally we have heard stories that people have died from waiting for elective surgery. The bottom line is we're not giving equitable access to Tasmanians to help service the universal health system.

Mr OSTLER - On bed block and emergency, I think over winter - because I guess that's part of the reason we're here - there was a lot of tension; the emergency department seemed to have tension with wards. James is often an after-hours manager and there was tension

between those groups. Part of that was because the emergency department is full, it's really pumping, they need to get people out but the wards are full. There's no more capacity, unless we flex up, without staff often. That was happening regularly through the winter. I was shown emails between senior ED staff and after-hours managers basically accusing them of being incompetent and conspiracy. It got to the point - and I wasn't there that weekend or I might have called a code on a person and searched the hospital for empty beds from emergency. This is the kind of culture that's developed. They went around and counted beds and there were beds, but they were unfunded and beds we weren't meant to open. The in-betweeners, the bed managers after-hours particularly, then say, 'My God, I'm under so much pressure from the emergency department, I have to put some of that pressure on the wards'. There is more than subtle pressure often on wards to put patients in beds, but you aren't often staffed for it. That happened throughout the winter, which was very disappointing. The best-case scenario is that the pool gives you staff, but unfortunately that couldn't happen on many occasions. The rostering office does a really good job -

CHAIR - Because there wasn't staff available?

Mr OSTLER - No, there is no-one. Then the next shift is down and the ratios are right down, everyone is tired and angry.

Ms FORD - And mistakes happen.

Mr OSTLER - That's right. It's a nasty situation. There is a conflict between departments because of different pressures.

Mr LLOYD - From my point of view, this all comes from the leadership, starting from the top all the way down. A lot of these things could be solved with good leadership.

Ms ELLIS - I absolutely support that.

Can we maybe move on, looking at the time and worried we won't be able to put all our points forward. These extra beds have been at the North West and the Royal Hobart Hospital. The LGH has put in a strategy of appropriately opening up beds through planned appropriate FTEs. We don't have that same crisis because it's a much more managed approach at the LGH.

I will move on to workforce, and I think we've touched on a lot of these issues. In budget estimates last year the minister announced around 170(?) *inaudible* had been retrenched during the budget cut process and that has now left us in an untenable situation. I think the reps indicated the use of double shifts and roster shortages being filled by casuals. It's such a false economy when you're starting to use overtime to staff normal rosters. The other major factor is there's been a change to the relief factor for every full-time equivalent of a nursing position, which in effect reduced the permanent nursing staff at the Royal Hobart Hospital by approximately 40 full-time equivalents. They are reliant on casuals and double shifts at the Royal. Over the last three months of the winter period, 420 double shifts were worked just at the Royal Hobart Hospital. We are seeing double shifts now becoming very much part of the problem with not only patient care but morale. There some of those concerns coming out of the difficulty to recruit. We've had many positions retrenched, we've gone too far too hard because now

we know we need more nurses and now the recruitment process is to get more nurses back. There has been a recent document from EOP confirming that it took four months to recruit one nurse, so if recruiting one permanent position takes on average around four months, that's four roster periods we're going to be short and rely on casuals, and that's a much more expensive option. So they can think HR are not supporting the needs.(?) I will pass over for some more information about what's happening with staffing.

Mr LLOYD - One of the interesting points Neroli has just made is that a nurse, or anyone in the public service, can give two weeks notice that they are going to leave but it takes up to four months to recruit someone. So between when they leave and when you get someone you have either to use overtime or casuals to fill in. If there are no casuals you have to use double shifts and it's these inefficiencies. When we do our pageup, which is the HR system for when people change or we recruit people it has to go to your manager and them someone else's manager, then it sits on Jane's desk and then has to go to redeployment and everyone has to tick it off before it gets to the end of the chain, plus interviewing and so forth. That is one of the inefficiencies of the system and that is in some ways why we have so many double shifts and overtime because there is this big gap between when someone can leave and when you can get someone new. It is very slow and inefficient.

CHAIR - How could that be improved?

Ms FORD - Even if you know someone is leaving in three months you cannot do anything until they leave. If you could start the process three months before you may have a month or whatever it is. You still cannot advertise for the position.

Mr OSTLER - It is not so bad as James runs the pool at the moment. I steal James' staff. I then give them casual contracts as people leave. That is one way I have avoided that and the job cards only take through that process about two weeks. The problem is permanent positions and for me the biggest problem is when we lost the relief factor off the wards. They were nurses sitting there and they are looking at you, they are keen for a job, you can employ them. I've had three in the last fortnight walk into the office and say next year when they finish their grad year they would really like a job and I can start that process off because they are already in the system. The ones outside are a problem. I cannot employ them into FTE that I don't have, and I think we have lost too many now from the ward that were meant to be supplied from the pool however ever since this happened they can't supply. They cannot employ people. Well, they employ some, there is no doubt about that, but nurses or indeed any workers like a permanent job, but the pool only offers casual. That is okay for a select few but really nurses, particularly women I think, look for a job that is permanent so that they can go to the bank for a loan to buy the house and do all those things that I think people are entitled to.

Mr LLOYD - I have a quick example of what Andrew is talking about. I had an enrolled nurse whose contract was up on a ward and she was not able to get a fixed-term contract so she has gone to Calvary and got a permanent position there so she can get her loan because she cannot get one at the Royal. It's not because she is not competent or anything. I employed her on a casual so she can do work but nurses won't wait for that. Nursing is a very portable profession, as you may or may not know, and they can go and get work elsewhere and we lose them very quickly.

CHAIR - If you don't give them permanency.

Mr LLOYD - Exactly.

Ms ELLIS - Maybe if I could just also touch on graduate nurses member for Pembroke for getting the figures on question without notice. Vanessa, I don't know if you have the figures there with regard to graduates but it is a bit frustrating when the minister doesn't use the full and true figures that are available. We are talking about full-time equivalents - most positions are part-time jobs, which doesn't compare apples with apples.

For 2010 and 2011, which is a normal year pre the budget cuts where the department put on 174 full-time equivalents from 2010. In 2011, 159 full-time equivalents and that was the requirement to have a workforce going into the future. Since the budget cuts it has dropped to 100.93 FTEs in 2012 and it is planned to be around 100 for 2013. We have lost in effect around 40 per cent of our graduates due to the budget cuts. That is going to leave us in an absolute crisis in around three or four years time when we know the significant bulk of our workforce are planning to retire around that time frame. The budget cuts are going to have a significant effect on our workforce going into the future and potential recruitments, the way graduate nurse positions have now been cut.

Mr LLOYD - One of the other things with graduate nurses is we bring them in for their graduate year and then we're just letting them go. They go to UTAS and do the qualifications, they want to be in Tasmania and work here. We give them a year, and we train them up. I remember late last year when I would go around the wards and the senior staff would be exasperated because they had these great graduates they wanted to keep and they'd trained up and the system just lets them go. They go to the mainland and to London but it's crazy because we need them to stay here. As Neroli said, in four years' time with all the people retiring we're going to have a shortfall. We should be keeping them here with us and working here and getting them mortgages so they will stay here. It is all very short term - what's it going to be like in the next three months. It's not something the health department is really thinking about.

Ms ELLIS - Probably the last thing that is being considered is training and professional development for the workforce. That seems to have been the first thing that was cut - offering ongoing training and education - so we're a bit concerned about that, too.

Ms FORD - Prior to the budget cuts, for the first time specialist clinics had a clinical nurse educator. As soon as the budget cuts came in we lost that clinical nurse educator, so we don't have anyone to help support the staff to do their mandatory training, and get professional development. With the introduction of the Australian Health Practitioner Regulation Agency - AHPRA - we have to get 20 Continuing Professional Development - CPD - points a year, so we've lost that avenue that had just been provided to us, through the budget cuts.

Mr WILKINSON - So what happens?

Ms FORD - We have to beg, steal and borrow other people's sessions, or people are having to do it in their own time - find their own CPD.

CHAIR - If they can't, AHPRA won't register them.

Mr WILKINSON - That's right. If they won't register them, they have to find it somehow, but sometimes they can't.

Ms FORD - The hospital used to run a mandatory day that was a full day's program and had all the mandatory skills in it, but that's now been disbanded.

CHAIR - Even the CPR management training?

Ms ELLIS - The CPR medicating management, occupational health and safety issue, and fire drill - are now not available to everybody.

Ms FORD - They're still mandatories but they're not finished off in a day. You could release a staff member for a day, and they could go and get everything done, but now you have to find out where they're all happening, individually. That's where the coordinating role of the clinical nurse educator was very helpful. It's another job, as a NUM, I have to now pick up.

Mr LLOYD - I'll give you another example of how the budget cuts are affecting our efficiency. Just recently there were a lot of enrolled nurses who graduated from the Polytechnic. There are no resources or educators to run a graduate program next year at the Royal Hobart Hospital so they can get into the system. A lot of people are coming to me asking, 'Can I join the casual pool?', and I am saying, 'No', because I can't. I can't employ someone who has had no clinical experience. Here we have a young, enthusiastic, cheap - and I mean cheap as in financially affordable - workforce who want to come and work for us, but we can't employ them because we don't have any supported positions or no-one to support them. Even if I was to employ them into the pool, I don't have anyone to support them. You cut funding for the educator, and that saves money but then there are all these workforce implications that are not thought about.

CHAIR - Are there any other workforce issues?

Mr OSTLER - Employing more graduate nurses is a good idea, returning the numbers to establishments on wards. I estimated since July there have been approximately 750 nursing double shifts. I know the surgical number, and medicine is about the same size. Instead of paying 750 nurses at, say, $75 an hour or something, it would be more cost effective to pay a graduate nurse, who is getting $20 something an hour. I could probably employ three graduates per double shift, and I think that's a far more responsible thing to do. I can see that as a win - if we can get some commonsense back into where staff are put. Not in the pool - they should be put back in the units that need them. In the month of August, where we kept a close eye on it, we worked 36 shifts where we needed a double shift, and we only got 12. There was no-one available and you've already utilised the pool and drained it, and that is across every month. That is a particularly bad month, August, but general surgery and orthopaedics all suffer this across the board. It's the same problem for them.

Ms ELLIS - Ruth, do you have all the workers compensation statistics and the cost to the Department of Health of workers compensation - the increasing costs that are occurring?

CHAIR - No, we don't have those figures.

Ms ELLIS - I will get those to you.

CHAIR - That would be good. Over what time period do you have those, Neroli?

Ms ELLIS - Over the last 12 months - the most recent figures for workers compensation - the various claims and types of claims, particularly for Mersey, have escalated. It's going at a higher rate than the private sector, or anywhere else.

CHAIR - Do you have a comparative figure for the last couple of years you could provide as well?

Ms ELLIS - I have a full report and I'll forward that to you on Monday.

CHAIR - Thank you.

Ms ELLIS - Thank you very much for listening to our comments. Patient care is the bottom line for us. It is having an effect on Tasmanians, and the workforce, and the problem is how we're going to recover. We are concerned about the future, not just the crisis here and now.

CHAIR - Thank you very much for making yourselves available today. We appreciate it.

THE WITNESSES WITHDREW.