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THE JOINT STANDING COMMITTEE OF PUBLIC ACCOUNTS MET IN COMMITTEE ROOM 2, PARLIAMENT HOUSE, HOBART ON FRIDAY 9 AUGUST 2024

ROSTERING OF SPECIALISTS

The Committee resumed at 1:40 pm.

CHAIR - Thank you Minister for coming back, or staying perhaps maybe more the case. Just for those who may be tuning in at this point, welcome to the Public Accounts Committee inquiry into the follow up audit of the Attorney-General's report of 2015/16. It's been a long week, the Auditor-General's - this one's into the rostering of specialists. Just to make sure we're right on that.

One of the roles of the Public Accounts Committee is to work with the Audit Office to see which reports to follow up, and we work with him to make sure we don't choose the same ones. We've chosen to do this one. The purpose of it is to understand whether the Department have adopted the recommendations, if not, why not, and what evidence can be provided to show that the recommendations have been adopted where you claim they have.

I will get you to introduce your team in a moment and get them to take the statutory declaration, but I will just remind you that everything you say here today is covered by parliamentary privilege .That may not extend once you leave the room. It is being broadcast and transcribed by Hansard. It will form part of our report. If there's anything of a confidential nature you wish to share, you can make that request. Otherwise, it will be in public session. Do you have any questions before we start? No, okay. You may not know members of the committee this is Secretary Simon Scott at the end, Luke Edmunds, member of the Upper House, Josh Willie, former member of the Upper House now Lower House, myself Ruth Forest, the Chair, Bec Thomas, Upper House member, Mark Shelton, Lower House member, and Simon Behrakis, Lower House member.

Mr BARNETT - Thanks very much Chair, thanks for the opportunity. On my left as the Acting Secretary, Dale Webster, and on Dale's left is Dr Kate Burbury, who is Executive Director of Medical Services and Research, Hospital South

Dr KATE BURBURY, EXECUTIVE DIRECTOR, MEDICAL SERVICES AND RESEARCH DEPARTMENT OF HEALTH WAS CALLED, MADE THE STATUTORY DECLARATION, AND WAS EXAMINED

CHAIR - Now, I'll invite you Minister to make an opening statement, if you wish. We have your response to the questions sent to you asking for you to provide some evidence of your response to the Auditor-General's report - not being so old, this one, 2019/20.

Mr BARNETT - That's right. Thanks so much, Chair. Thanks for the opportunity to be here. As a Government, we're committed modernising all aspects of our health service because we know it delivers significant benefits not only to staff in terms of better supports and recruitment, but also for patients who benefit from the flow on effects and having access to more health services sooner. The Department's developed a comprehensive long-term workforce plan, the Health Workforce 2040 Strategy, and I will be tabling that document today. I do so now.

To ensure we have an eye to the future in terms of what our state needs in our Health workforce and regarding rostering specifically as part of their ongoing work, I can advise the Department of Health is introducing a best practise rostering framework. The framework will outline the goals, objectives and initiatives to steer the direction of rostering improvements, which has included actively developing a clear understanding of current rostering practises across the Department. This work will ensure the appropriate training and education is undertaking as we transition to the Human Resources Information System, HRIS - however we want to say it, another acronym for all of us to get our heads around. This will provide a better and more modern process in terms of automatically paying our staff by their rosters, which I think we can all agree will be welcomed by all. The Department can expand further on this, but an implementation plan is currently being developed which will be staged to allow for adequate training.

Finally, while there are existing statements of duties for individual positions, I can advise the Department is transitioning to a standardisation of job descriptions, which will improve efficiencies in terms of advertising and recruitment and result in more targeted job advertisements that link to mandatory training requirements relative to the job.

Finally, I do also table the One Health Culture Program Strategy 2022 to 2027, Shared Purpose, One Direction, One Health. Thank you, Chair.

CHAIR - Thanks, Minister, I note in your response and also in the letter you provided to us you mentioned the HRIS, I am interested on its health and well-being and how it's progressing? Are we getting closer to implementation?

Mr BARNETT - Thank you for the question. I think the Acting Secretary, Dale Webster, would be good to answer that one.

Mr WEBSTER - Thank you for the question, Chair. So, HRIS, is that what we're calling it? We have gone through the procurement stage, we have gone through the development of the system stage. The first module, which is a case management module, will in fact be switched on in coming weeks in health and, in fact, in a number of other agencies quickly following that. That is the first step. We expect that the full system will switch on in health as the first agency in late 2025, perhaps the third quarter of 2025, with other agencies then following, because HRIS is a whole-of-Government HR solution, with health being the lead agency for implementation.

CHAIR - It's had a long gestation, this one. Okay, we look forward to that because then we will have all sorts of data from you, won't we? Anyway, in the response, we have noticed here that developing this best practise rostering framework and the roster innovation and strategy team have undertaken discovery stage, which has included actively developing a clear understanding of current rostering practises across the Department. One of the reasons this audit was initiated was because there were some concerns about some of the rostering practises. Can you indicate to me and the Committee, Minister, what was found during that review, if you like?

Mr BARNETT - Yes, thanks very much. I think it is best, of more of an operational matter, if I pass to the Acting Secretary.

Mr WEBSTER - Through you, Minister, to the Chair, firstly, what we found is firstly we have rostering, that's anything from someone scribbling on a piece of pad paper, through to a system called ProAct. ProAct is in fact a very modern, easy way to roster and we have introduced it for nursing across the whole Mersey. It was used throughout COVID[1] for testing and vaccination programs. Unfortunately, it is not fully integrable to HRIS, so we are working through those issues.

As part of HRIS, we need to actually get everyone onto an automated way of rostering rather than the current thing and, as you would appreciate, we roster everyone from admin people to senior specialists. We've gotta have to have a system that's fit for all of those and can then automate into it. You know, in the findings of the audit, the Auditor-General highlighted particular risk with the manual way that we do timesheets and rostering and things like that.

One of the blockers to that was, in fact, with doctors, that we didn't actually have an industrial agreement that allowed us to do some of that automation. So, in last year's EBA that we signed off, it actually includes an agreement to move doctors into an automated system. That was actually an industrial blocker to automated systems of checking in and checking out of hospitals and things like that, but we now have agreement to do that going forward.

CHAIR - How is that progressing then?

Mr WEBSTER - Through you, Minister, that is progressing - so we have done the first step, which is the reviews, we know what the rosters are. We are now looking at if we do the upgrade to ProAct so that it will integrate with HRIS or do we go with another product. We are looking at another product, but commercially, I probably can't name that one here, but we are doing that assessment so that we can then build it in our rosters and then have, you know, for want of the better thing, and I would describe them as 'swipe in, swipe out,' but that is actually not what they are in reality, but the old-fashioned clock your time in, clock out. Away of automating when our staff have come to work and when they leave.

Now, for some of our staff, and particularly specialist medical practitioners, some of that clocking in, clocking off is actually them working at home, giving advice over the phone. It's actually a complex thing we need to work out. How do we actually pick up that time automatically? As well as their presence within the hospital, giving Kate the tools to roster hundreds of doctors across the RHH[2] as we go. All of that has to integrate.

CHAIR - One of the concerns detailed in the Auditor-General's report is that some doctors who might have been rostered were perhaps not there the whole time, but going and doing some private clinic work and then coming back.

Will the system deal with that as well as the capacity to change rosters quickly? People get sick and all sorts of stuff.

Mr WEBSTER - Yes, that's precisely what we're looking at. The reality is a lot of our doctors do not work a nine to five day: surgeons, anaesthetists, et cetera. It might be actually quite valid they're doing three hours in the morning in the public system and then they've got three hours in the private system before they return. It might be because that's the scheduling

[1] Coronavirus disease 2019
[2] Royal Hobart Hospital

of the operating theatres. We need to account for that in how we roster, but how we log that the doctors with us.

CHAIR - You can throw an emergency caesarean in the middle of it and it completely mucks it up.

Mr WEBSTER - Yes, exactly. We've talked about the long gestation period of human resources information system, but these are the levels of complexity that have to sit behind a human resource information system for health. We were chosen to go first in the whole-of-Government rollout because we are by far the most complex.

The theory is if it works in Health, it will work anywhere.

CHAIR - I don't expect you to name the different other option models, but are there models in Victoria, New South Wales, Queensland that operate obviously similarly complex - perhaps even more complex in some cases - systems where it can help guide that decision making.

Mr WEBSTER - Yes, there are and that's -

CHAIR - That is where you are looking.

Mr WEBSTER - We are looking at what's happening elsewhere and you know, through the early part of HRIS we had advisers on board. We had Mike Walsh who's from Queensland, but Mike has left the project because he's now Secretary of the Department in Queensland. We had a high level of advice from Queensland about their experience with implementing a human resources information system, because they were the first to go down the complexity model and had a few missteps.

CHAIR - How long have they been doing it?

Mr WEBSTER - They started probably about eight to nine years ago.

CHAIR - It does take a while then.

Mr WEBSTER - Yes.

CHAIR - The stage implementation, acting secretary has touched on Minister, but you sort of indicate there's nursing at the Mersey being utilised in that PROACT System but with the stage implementation, is it to start with the nursing staff or how are you going to stage it?

Mr WEBSTER - In terms of switching on the major module, we intend to do that as one thing. We need everyone to be at the same stage.

CHAIR - All health professionals?

Mr WEBSTER - All health professionals. In terms of where we've gone with, with PROACT in particular, we started with nursing because it's by far our largest workforce and then we're now working out how should we roll it out to others. But we have used PROACT

for administration in the north-west, it's used for allied health, which comes across both North West Regional and Mersey.

It's used in more than nursing already but as I said, it's working out - is that the system we're staying with to integrate or whether we actually need to convert to something else.

CHAIR - Are there any other industrial barriers here? You've mentioned the medical professionals.

Mr WEBSTER - There were a number of across all of our agreements. Things like how we do multiple employees. Someone who's paid as a nurse in health part time, but also a nurse in education part time, but in health they're a nurse unit manager; in education they're a base grade nurse. Now we actually manage to pay them two different rates of pay to the same person across Departments, but also within our Department. There might be a CHaPS[3] nurse two days a fortnight who comes in and is nurse unit manager in the ED[4] over a weekend. We've had to work through, industrially, how do we actually build that into a system? There's a number of other things like that. We don't have common spreads of hours. All of those complications that come with different awards that we've been working through. In last year's agreement, we had the list of what we needed to fix for HRIS and we did all of them in the round of agreements across all the different awards.

CHAIR - With regard to the third recommendation, which said, 'Consider the mandating of the use of timesheets in all hospital Departments either electronically preferred or manually'. Your response to that was that the HRIS system will provide roster-to-pay process once implemented. You go on to say that the roster-to-pay process will provide real-time transparency in relation to hours worked. I go back to that point that I don't imagine there's a way that they can actually assure that the person is actually working and not, say, perhaps supervising from afar?

Mr WEBSTER - One of the complications we're working through is that, but we are actually pretty confident we can create system-based - that person, even though they're supervising from afar, and they may be at home doing that, you know that they are using our system. It logs that they're into our IP[5] address. I don't know the exact IT terminology, but it actually logs the use of systems and those sorts of things as a way to do that. I should probably go back and say we are using the manual timesheets universally now, but you know, they're only as valuable as -

CHAIR - And they're not just a scribble on notepad anymore, though.

Mr WEBSTER - No. We actually have a timesheet format, but you've got to fill them out and you've got to get them back and those sorts of things. It adds complications, but having an automated system will be a much-improved system.

CHAIR - If you had a medical specialist doing a list in the morning, let's say an anaesthetist or a surgeon or someone doing some specified time in the operating theatre list and then they go and consult in their private rooms, but then they come back in the afternoon to do

[3] Child Health and Parenting Service
[4] Emergency Department
[5] Internet Protocol

patient rounds or whatever, how will you initially check that when they go off to do their private work, because they're not then working for the public system, how do you track that?

Mr WEBSTER - That's the 'swipe in, swipe out.' So, they've swiped out of our systems and then they swipe back in when they come back in to our systems -

CHAIR - You rely on them doing that?

Mr WEBSTER - Yes, exactly. We rely on that with timesheets, but it's more automatic because the first thing they'll do is need to log into our Digital Medical Record, in the future, the Electronic Medical Record, which will be far more sophisticated, so they've actually logged into a system and when they leave, they're logging out of that system. We're hoping, when I say, 'Swipe in, swipe out', it's more -

CHAIR - A log in, log off, type of thing.

Mr WEBSTER - It's a log in, log off. For some it will be literally swipe in, swipe out in some circumstances.

CHAIR - Recommendation 4 said:

> Develop a statement of duties for all Heads of Department, invest in transitional ongoing managerial and leadership development in those roles.

You've said you've been rolling out health leadership and management training to build the capacity in the Department or Department's leaders and managers. Can you give us an update on how many percentage-wise - not just the numbers, they don't mean a lot if you don't know how many people there are - doing that training?

Mr WEBSTER - The Minister tabled the One Health strategy. We've rolled out a series of programs and they have names, we start with Base Camp, which is sort of basic supervisory skills. We then go through Aspire, which is the middle managers, Elevate, which is senior managers and then on to other things. We also, through the EDMS[6] office, have various programs such as the Fellowship of the Royal Australian College of Medical Administrators? I got that right, okay, for our doctors. Chair, I do not have a number or a percentage of staff, but this program started now about 18 months ago and we run cohorts constantly through the program. Targeting our middle to senior managers to make sure they have the skill sets to do this.

In addition to that, we run with the private sector, a thing called the Leadership 2040 online community which supports sharing of leadership information and training et cetera, but online. That is backed up by an annual 20 Leadership conference, but that is a whole-of-health system, not just a health service program: the Leadership 2040. We specifically, I know it is not in this audit because this was about doctors, but specifically for nurse unit managers, we actually run specific programs for them around leadership et cetera. For our senior nurses, we actually have what's called the nursing master class that our chief nurse operates and it runs on a regular basis.

[6] Executive Director Medical Services

CHAIR - Is it possible to get numbers of those who have done it? We can put that to you on notice. We are just seeking evidence, the fact that you have actually done it.

Mr BARNETT - I think we can help with that. We will help you, Chair. We will respond to that if you are happy to put that on notice.

CHAIR - We will, yes. Number 5 was:

> Consider recording time scheduled for private practices -

which comes back to the point I was raising a bit earlier -

> on other premises in specialist rosters to increase transparency, assess fairness and to better manage specialist fatigue

which is obviously important too. Minister, your response stated that the current project will develop best practice rostering and will consider this issue. When you say, 'will consider this issue', is that integrated into the rollout? I was a bit unclear about what that meant.

Mr BARNETT - Yes, I think is the short answer, but I think Mr Webster would be best to answer that.

Mr WEBSTER - Yeah, the intent is to actually have that but we will also move forward. We have stronger agreements now with doctors about what hours are hours and what hours are private. It's also complex because we have visiting medical practitioners who are private doctors who give us some hours, versus our salaried medical practitioners who are our doctors who might work part-time and then do some private work. There are different models for different categories of employment.

CHAIR - There's probably a similar response with more colour to Recommendation 6:

> Assess whether Departments need to factor in appropriate levels of non-clinical time to rosters to enable specialists to better structure their working days.

That is about managing fatigue and other matters. Did you want to add any more to that because it's a pretty vague response with all due respect.

Mr WEBSTER - Each of the colleges and organisations recommend a number of hours you should have in non-clinical roles. That is to do things like do your reports; make sure that DMRs are up to date, do the supervision of junior doctors, those sorts of things. That is a requirement of the college. In last year's EBAs,[7] we strengthened the clauses around providing that time to the doctors to make sure they get that. We also built in what we call learning time for junior doctors to make sure that our registrars are getting time away from wards to actually do their learning as well.

CHAIR - That would be nice for them.

[7] Enterprise Bargaining Agreements

Mr WEBSTER - Yes. We have strengthened that through our industrial agreements and then we can build that into the rosters and HRIS going forward.

CHAIR - Any other questions, members? Okay. I don't have any more. We have covered all those recommendations. Is there anything you wanted to say in closing? Either you, Minister, or anyone at the table?

Dr BURBURY - I might add to a couple of comments, Dale, if that is right, to what you have added. Particularly, I will work in the reverse order, with the clinical support time. It is sort of a mandatory 20 per cent. What this will actually do is be built into the work plans and the statement of duties - which probably hasn't been done before and that really lends to what the Minister and Dale were referring to, is getting a more systematic way to the way we map our days.

That is going to be fundamental to the rollout of any information system. I've lived and breathed the rollout of an information system in my previous place of employment and at EMR, and the reason why the gestation is so long is there's a whole lot of components. It doesn't have generative AI. You have to build the design and the decision-making behind it. The starting point is actually what is expected of our staff in terms of their minimum statement of duties, but more importantly, how does that then get applied in a work force plan? Getting the EBA up to speed was the first step and then us actually applying it to our staff is going to be fundamental to that rollout.

The second thing I wanted to add is it's not so much the swipe on, swipe off in a moment to moment, but what it'll actually do is give us the data discovery to understand what our current work force is and what our current skill set is, but more importantly, what our unmet needs are. Then we can impose that on our training and research, recruitment, attraction and so forth. So again, there's a runway, but the runway can be for us to do all of this discovery and map it out before the system gets rolled out. That's critical for a place like Tasmania in terms of the work force going forward. We really don't have granularity in terms of what our current establishment capability is, but what we need for our future. I think that's important going forward.

CHAIR - Minister, has there been any pushback, particularly from the senior specialist that this audit referred to, in developing this work? I know that's not live at the moment, but they would know it was coming, I imagine.

Dr BURBURY - Absolutely. It's not a big brother approach in terms of micro-managing our behaviour, but rather creating a fundamental culture across the organisation. What does it mean to be a ward specialist and how many patients should you be expected to look after or what your expected deliverables are, or as a radiologist, how many scans you should report? It's fundamental to what we do as professional specialists and it's an opportunity to unpack that and look at what is expected of us as professionals, but then also what we would need to do to achieve that minimum standard that's expected of us in the work force.

CHAIR - Will it also helped to ensure that the workload is being evenly shared?

Dr BURBURY - Exactly.

CHAIR - That was one of the concerns that was raised.

Mr BARNETT - Kate summarised those key initiatives and how it's going to roll out quite well. At the end of the day, we want to build a better health system - it'll deliver better health services. That's where we want to aim and put the patient at the centre, which I've said many times. They should be at the centre of our health system so that we focus on better health services.

CHAIR - We do need healthy medical staff to look after our patients as well, though.

Mr BARNETT - That's right.

CHAIR - Thanks, Minister, for your time and for your team. We appreciate you appearing today and providing that further information to us. We'll write to you with those other couple of matters to follow up.

Mr BARNETT - Thank you Chair and thank you Committee.

The witnesses withdrew.

The Committee adjourned at 2:08 pm.