THE LEGISLATIVE COUNCIL GOVERNMENT ADMINISTRATION COMMITTEE A MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART, ON WEDNESDAY 1 FEBRUARY 2012.

COST REDUCTION STRATEGIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms NEROLI ELLIS, SECRETARY, **Mr ANTHONY BRADLEY**, **Ms ROS GORRIE** AND **Ms JULIE DRIVER**, AUSTRALIAN NURSING FEDERATION, WERE CALLED, MADE THE STATUTORY DECLARATION AND WERE EXAMINED.

CHAIR (Ms Forrest) - This is our first session since the Christmas break and things may have changed since you put your submission in. I know Neroli has given evidence before a committee but I am not sure about the others. The evidence you give is recorded by Hansard. You can speak freely and give us an overview to start with, if you like, and an update on where you see things are at the moment. If you want to cover stuff that you prefer not to be in the public arena and to give it in camera, you can make that request and the committee will consider that and decide whether we support that request or not but otherwise it will be in the public arena and then on the public record and the *Hansard* will be put onto our committee website at a later time. You are protected by parliamentary privilege so what you say here is protected but if you repeat anything outside, it may not be, so keep that in mind.

We received your submission in December and have read that, and obviously things may have changed somewhat from then. There is quite a bit of information in there but you might like to give an overview and then an update and we will focus on saving strategies and what impact they are having. That is why I am keen to hear from you. We now have experienced those cuts for a period of time and the evidence may be becoming more apparent at the coalface.

Ms ELLIS - Thank you very much, Ruth, and thanks very much to the committee for the opportunity to address our paper and to provide some more up-to-date and relevant examples of the true impacts of the budget cuts, although it is still early days.

I would like to introduce the nurses who I have brought with me today and let you know where they work. Certainly they will be giving live examples from their perspective and their specialisation of what they are seeing on a daily basis in regard to the cuts. Ros Gorrie is a community mental health nurse working at Gavitt and Tolosa. Tony Bradley is a nurse practitioner working in the Emergency department at the Royal Hobart Hospital and Julie Driver is a neonatal intensive care nurse and a pain management specialist working at the Royal Hobart Hospital as well. We will be doing a joint submission and I do take it that you have a copy of our submission in front of you because I would like to work through that and give you an update based on those headings. I think that is probably the only way really to work through this but, as I said, we will stop at each of those sections and the nurses will give examples, et cetera, and we are happy to take questions, if that suits the committee, to work through this.

CHAIR - Yes, that would be good, thank you.

Ms ELLIS - If I could just table the up-to-date data. It is very difficult to get data from the Department of Health and this is based on our nurses giving information back to us and our meetings with the CEOs of each of the regions so this is up to date as of 1 February and I will just table that.

CHAIR - Thank you.

Mr WILKINSON - Neroli, you are saying it is difficult to get data from the DHHS. Have you endeavoured to get data from them and they have advised you that they are unable to give it or they haven't bothered?

Ms ELLIS - It is very much part of the culture of the Department of Health and I think unfortunately it stems from the whole Government. Originally the information that was given out to the public around, as an example, what the savings were was, we would say, very misleading. There were two different sets of numbers given out to the public through the media. One was called The Savings Targets, as an example, for the northern area which was $18 million to $20 million. However the budget deficit, which was the real money that had to be gained, was $39 million and similarly for the Royal it was around about $30 million but the budget deficit is really $60 million. It is that sort of information and lack of absolute transparency and we are finding now that a memo has gone out to all LGH staff and NWRH staff to say that not one staff member can give information to the ANF unless it goes through the CEO otherwise there will be disciplinary action, so there is certainly this culture of not sharing and not being open with the information.

It is pretty simple, we would think, for a billion-dollar corporation to say how many beds are closed to date, what FTE of nursing has been removed to date, what FTE medical staff. We would think this information is not highly technical, but it has been very difficult to get it.

CHAIR - How have you got this information together, Neroli? Is that just from what the nursing staff have provided?

Ms ELLIS - Or from CEOs' documents. We have monthly meetings with all the CEOs, the joint union consultative meetings, where we do get this information so it is as accurate as we can possibly get. Some of it has been given to us from the executive directors of nursing so most of it is officially given to us but some of the bed closures have been a bit caught up in, as an example, closing Ward 4D which was a medical ward at the Launceston General. There are 24 acute medical beds closed. However they have since opened up the ANU which is a short-stay unit out at the ED which was Commonwealth-funded so they are saying there are 20 beds there and therefore it is only a net loss of four beds. That is quite incorrect because that was Commonwealth funded and in the State Budget 24 acute inpatient beds have been closed. That ANU is open any way with Commonwealth funding.

CHAIR - Neroli, does the Commonwealth fund the operation of those beds or just the building?

Ms ELLIS - The building and some set-up funds. They were set up in relation to the national target of four hours' turnaround for emergency patients so there has been some incentives from the Commonwealth, some funding coming in from the Commonwealth, to try to assist in meeting national targets coming up to the national health reform.

CHAIR - I am just being the Devil's advocate here, but the State could claim that because they still have to pay the operational costs and the staffing costs like the nursing costs and that sort of thing to run those beds, it is their cost?

Ms ELLIS - No, sorry, those staffing costs for the ANU at the LGH are coming out of Commonwealth funding. When that health reform came through it was funding for the infrastructure plus the staffing so the subacute beds had staffing funding attached, to my knowledge.

CHAIR - Thank you.

Ms ELLIS - There was an additional requirement for the new infrastructure at the emergency centre that opened up at the LGH this week. We have already gone off at a tangent, haven't we? It is a wonderful unit of 43 beds and the new ED can only open up half of that because there is not enough staff to open up the full unit, so there are another 18 full-time equivalents that are required and that apparently is going to be granted through Commonwealth funding.

Mr WILKINSON - It is important that we find out what is going on there because if you are not given the figures we may not be able to get the figures as well and the only way you can come back with proper recommendations and conclusions is if you get the proper figures. If you don't, that makes it impossible.

Ms ELLIS - Absolutely, and with any informed decision making you have to have the facts on the table so when we are meeting and trying to work in partnership with the CEOs, with our reps at a local level without that data and the true information it is very difficult to make sensible decisions. We have found that with this whole process being unilaterally driven anyway; the CEOs certainly have not been contributing and have been directed from above to implement those changes, and we all know that they are not in the best interests. There has been limited consultation with the clinicians and the CEOs in the first instance. We went to many meetings where the CEOs had to just put on the table the documents that came from central bureaucracy and said this is what we have to do.

CHAIR - From the budget control team? Were they getting a directive from there?

Ms ELLIS - No, it was more from the Deputy Secretary, Alice Burchill, who was certainly releasing many of the documents and some of those documents were released without the CEOs even knowing they had come out, they were being publicly released. The process has been incorrect. The whole strategic approach has been incorrect, and maybe I will start off with my submission.

CHAIR - Yes.

Ms ELLIS - But there will probably be more examples of that sort of difficulty in finding out what is going on and particularly when we talk about risk assessment plans and implementation. A key issue is around the decisions that have been made have not being giving a clear, strategic direction or upholding a clear or strategic direction of the department. That is relating to 3.1 of our submission on page 4.

Tasmania's health plan was put in place. We have had a range of consultations of plans being put in place for our Department of Health over the last 12 years - the Richardson Report and the health plan. It is very clear that the health plan, based on demographics, based on thorough consultation across the State with clinicians, identified some critical growth that we would need to meet the needs of the future, being 345 additional in-patient beds by 2015. So within four years an addition of 346 in-patient beds and an additional 67 day-surgery beds, noting the addition to the ED presentations which we have already met.

What we are seeing now is this very short-sighted approach, knee-jerk decision making. There is no strategy. We have no idea and all of those working in the Department of Health, the nurses involved and nursing managers, really are unclear about where the Department of Health is going. What is happening with the service delivery, the amalgamations, the decentralisation or trying to bring specialised field into one area, or maybe not trying to deliver everything everywhere, they are all the key strategic decisions that have been made in the health plan for further consultation. That has just gone out the window. We do not know what is going on with that.

What we have seen that has been put in place is a new position, I believe, which is the acute clinical director, and that is a bureaucratic position. It is not attached to any of the area health services and this new position has been put in place to try to revitalise the health plan. We have met with this bureaucrat and that is another bureaucratic position put in place in amongst all of this, to help look at where the health plan now fits going forward but putting the cart before the horse. We say that they should have had a lead-in time to develop, to look at the systems, fix up the systems, look at the strategy where we are going and then, potentially, put in place, after thorough consultation and risk assessment, the changes that were required. It may have been a delayed approach and looks like we are going to find it is delayed now anyway because it was impossible to bring in the level of cuts that have been directed by Treasury to the health fund and to the health system safely.

So we are seeing changes being directed from the top. Even though we have consulted committees at all levels, whether it is mental health or whether in the kids services, we consistently raise clinical issues around how we are going to be able to manage. We have some anecdotes coming from ED of how can they mange when we are closing beds and have huge demands on our EDs; the same in mental health and wherever we look.

In remaining areas are things like cross-subsidisation, so the CEOs of the hospitals - and I can only speak for one region - are cross-subsidising the losses of the rural hospitals. That is not being taken into account also. That information from the CEOs seems not to be listened to.

Dr GOODWIN - Neroli, can you explain that again?

Mr ELLIS - It has been reported that some of the rural hospitals are opening 24 hours a day and these are political decisions to open up or maintain all the rural hospitals. I suppose it is like education. There potentially can be some reviews and some efficiencies. The bottom line is what is in the best interests of the community and health for that community. It may not be a 24-hour hospital; it may be. But they are making a loss, potentially. They do not have the budget, so they are going above their budget, into deficit, therefore the hospitals have to carry that burden. So it is the area health service now that has to carry it but effectively it is the hospitals that have to carry that burden and make more reductions to the hospitals.

CHAIR - Which rural hospitals are open that previously were not previously opened 24 hours?

Mr ELLIS - I suppose, politically, their decision to re-open St Marys, which was about four or five years ago; that had been closed. I think at the time Minister Llewellyn opened it because it was a political promise to open St Marys. So there is one example.

CHAIR - But in recent times there have not been any changes?

Mr ELLIS - No, not in recent times. Ouse is the only recent change to a rural hospital and it has certainly been reported to us that that was against the clinicians' and the community's desires. It has certainly been reported to us from very sound resources that it is now costing more in the current scenario than it was costing as a 24-hour hospital in that region.

CHAIR - I asked some questions about that last year, that are on the record, about the costs, but also Rosebery?

Mr ELLIS - Rosebery, yes.

CHAIR - I want to clarify that you are not suggesting that Ouse, for example, and Rosebery and St Marys and others have changed their hours of operation since the cuts were announced? That was all before?

Ms ELLIS - That's correct.

The decision making being taken away from the local CEOs has operational impacts. A more recent example is that we have a group of renal nurses working in the renal unit at the Launceston General Hospital. They do outreach at Kings Meadows. There's a demand for renal services as clients need more and more dialysis as required, so they now have to open on Saturdays to meet that demand. These nurses were employed as day workers; they're happy to do the Saturday to meet client need. There is a dispute now around public holidays for this group. The CEOs in the local areas said, 'Let's just fix it', however the bureaucrats in Hobart - and now we are in the Industrial Commission trying to fix it. Centralised bureaucracy is putting obstacles to operational smoothness and staff relationships, which is so vital in our culture and the caring environment we work in.

Mr HALL - On that second dot point from the bottom you talk about the RHH. Anecdotally GPs might say, 'Most problems with health in Tasmania tend to emanate from what

happens at the Royal Hobart Hospital'. Is that a fact? I know it's the largest hospital so do things tend to flow?

Ms ELLIS - The hospitals are the hub of the continuum of care, so obviously health prevention and promotion should be in the community. At some stage GPs have to refer through to hospitals and emergency services or for elective surgery, but it's that communication and lack of electronic records. It's the lack of involvement of GPs post-discharge that causes that break in continuum.

Mr HALL - As you point out, you have that instability with 10 CEOs in 10 years. That tells a bit of a story, doesn't it?

Ms ELLIS - Yes. Every time a new CEO comes in, they undertake further reviews. We've had this happen with the last couple of CEOs. External consultants come from interstate to do another review and another change.

Mr BRADLEY - In terms of general practice - I have worked in primary care as well - there is now a new group of people who can't afford to go to their GP. With the global financial crisis there are people who can't afford the $80 out-of-pocket to see a GP. So they're going to come to the hospitals' emergency departments, which is a one-stop shop. You can get your blood done, X-rays and medications at probably a cheaper rate from the hospital pharmacy. There's that new group of people who can't afford to go to those after-hours GPs or to the private emergency department. I'm seeing more GP presentations and I can understand why GPs can't fit more patients into a day, but there is that group of people who are now coming to emergency departments. That's going to bring our numbers up as well.

Mr WILKINSON - That was on the news this morning. There was talk of a drop-off in people going to their own doctors because they can't afford it, which is causing a backlog in the emergency department because those people are now going to hospital.

Mr BRADLEY - And regularly from the after-hours GP out at Derwent Park and places like that. You get patients that have come in from there because there is a four-hour wait out there as well. If they have to wait they will wait in the emergency department because if they need an X-ray they will come to us.

Ms ELLIS - Of the superclinics that have opened up, the one in Devonport does not bulk bill. Some of the superclinics were set up from the Commonwealth funding to try to alleviate those category 4s and 5s from emergency, which are traditionally GP presentations, but because they are not bulk billing they're still going to emergency.

Ms GORRIE - That's also an issue in mental health. A lot of the psychiatrists in private won't bulk bill. The people have to go somewhere so they come into mainstream mental health.

CHAIR - Has the ANF had discussions with the Commonwealth about bulk billing? What sort of response did you get from the Commonwealth?

Ms ELLIS - We are certainly raising it through ANF federally - not only bulk billing but also the actual access. These superclinics were set up to be much more accessible and a lot of

them are closing at 6 p.m. or 8 p.m. or not opening on weekends. We need superclinics to be open from 7 a.m. to 8 p.m. or 10 p.m., which was the original philosophy with superclinics. A lot of Commonwealth funding has gone into those infrastructures. We're also finding that they are potentially not meeting the needs of having allied health and the whole-of-holistic-care model. You still go to the GP and then you have to go into hospital to get your x-rays done and to get your bloods done you have to go to pathology, whereas it was meant to be a one-stop shop and it is not quite working out like that. Certainly. ANF is lobbying nationally and has been raising that issue with the previous minister.

The recent department progress chart report was 11 December but the majority of these changes came in during this period of time or at the end of that progress chart report time. The next progress report, which will be the quarter January to March, will be much more reliable in regard to the real impacts of the theatre and VET closures and the other reductions of community mental health and other services. We know that from the facts in front of you that 8.7 per cent of Tasmanians wait for elective surgery, more than a year and that is the second-longest delay in Australia. I think you can also pick up on the ED presentations and all the statistics across the board - there are some areas that we do meet but we do not meet national standards for the majority of areas. We have an increase in the number of presentations to our ED for a range of reasons, not just the GPs - but I will let Tony speak to that -

Dr GOODWIN - Neroli, that figure seems extraordinarily high, quoting that nearly 30 per cent of the population rely on emergency care from an ED.

Ms ELLIS - We are seeing more and more people going to the EDs, not only for the reason of socioeconomic needs but we are finding that it is about access and equity of access and after hours, particularly in some areas where there are no GPs. There is GP-assist on a telephone but there are still a lot of people traditionally going into the emergency departments. We are seeing around 3 000 additional presentations a year throughout the ED - do you see 50 000 to 60 000 a year?

Mr BRADLEY - Yes. We have just broken two records over the Christmas/New Year period where we processed 200 people in one day. When I started at the Royal Hobart Hospital four or five years ago 110 was a busy day and now 140 is a normal day. So the numbers are going up.

CHAIR - But some of that may be population increase, the age or demographic - is it not related to those things?

Mr BRADLEY - If it is population increase we are only going to keep increasing.

CHAIR - That's right. Well, it may not if people leave the State for work.

Ms ELLIS - A lot of nurses are leaving this State but it doesn't make much difference to the emergency presentations.

Laughter.

Mr BRADLEY - It is not just a Tasmanian figure, it is a national and international figure that emergency presentations are going up every year. We have better technology now and people are staying alive longer but with that comes the ongoing chronic disease management and those chronic people get unwell and need to come into hospitals and the way they come into hospital is through the emergency departments.

CHAIR - I just want to establish it is not something that is going to change dramatically because of the demographic, technology and the reality of our population.

Mr BRADLEY - That's right.

Ms DRIVER - And we haven't hit winter yet, wait until winter comes.

Ms ELLIS - There is also the addition now where we are seeing aged care as a growing phenomenon. We have lower levels of skill mix in the aged-care sector that with one registered nurse on after hours and between 60 to 100 residents that they are ultimately accountable for. If there is a fall, or whatever, they all come into the emergency department, which is the worst place for them, but with the current skill mix in aged care and the funding in aged care that is a reality as well.

Mr BRADLEY - Then we find the access block as well. Every Monday morning you can easily see 10 or 12 people waiting for VETs and they may have been waiting since Saturday.

Mr WILKINSON - How does that compare with other places? You say it is the same Australia wide, is it the same worldwide, in the developed countries?

Ms ELLIS - I think we are saying the increase in presentation is similar.

Mr WILKINSON - Similar all over Australia?

Ms ELLIS - What is actually happening in ED, despite incredibly new innovative-type models of care, the bottom line is that around 22 presentations at Launceston General every day need a bed and I think at the Royal it is about 40-odd. Every day those 40 people, as one of the 140 presentations, has to be found a bed. So when you start closing down acute beds and do not have enough beds and pre these cuts we were around 95 per cent occupied. So take away 40-odd beds - 50 beds at the Royal - it is not Einstein theory that we are going to have to be waiting over night and longer and longer in emergency, waiting for a bed because we are just not discharging 40 to 50 people every day out of the remaining 100 beds.

Mr WILKINSON - Are we getting discharges for people who shouldn't be discharged?

Ms ELLIS - I do not have any actual stats on that but it would certainly be an interesting stat. Anecdotally, nurses tell us that people are coming back on rebounds,, people who should not have been discharged as early as they were and they may not have been able to cope at home are coming back into emergency. I do not want to expand anymore because it is only anecdotal.

Mr HALL - Following on from Jim's question, Neroli, within the Australian jurisdiction you talk about 8.7 per cent of Tasmanians awaiting elective surgery - the second-longest delay in Australia - and that was prior to the cuts?

Ms ELLIS - Correct.

Mr HALL - Is there a benchmark State at the moment that is doing better than the others, given health is a very difficult area per se?

Ms ELLIS - I have not researched every single State individually to make an informed statement, but I'm comfortable to provide that information later. You have to look at a lot of indicators; it's not only elective surgery, its ED and meeting the triage presentations. There's a whole range of indictors you'd want to look at rather than just one section of it.

Mr HALL - Anecdotally I've also heard that a lot of Tasmanian nurses are moving interstate to seek work. I also heard the other day that with the latest crop of nurses it's minuscule the ones who have gained employment in the State.

Ms ELLIS - Do you mind if I come to that because it's quite a large section of our work force?

A classic example of poor decision-making is the removal of hospital-in-the-home service in the Launceston General Hospital, where clearly that was an efficient service that was meeting the community's needs. I think you have probably seen quite a bit of public campaigning. There were 1 309 care days that kept somebody out of hospital to have their IV antibiotics at home or their complex wound care at home rather than being in the hospital. That equates to around $1.5 million to $1.8 million of saved hospital beds, and that's now being axed. That service was at a cost of $175 000 to meet the needs of people with cystic fibrosis and early discharge into the environment. Ironically, that same hospital-in-the-home service is now being investigated to start up here at the Royal Hobart Hospital as one of the strategies to alleviate the Emergency Department. So we are closing it down in one area but it's now being seen as an effective tool and being potentially started up here and being maintained on the north-west coast. Up there it is very successful.

There was some snap decision-making without any consultation with the nurses who are involved in it. It was just axed with a week's grace. It's inappropriate decision-making.

Dr GOODWIN - Neroli, with that hospital-in-the-home program, are people's recovery times faster if they are being looked after in their homes?

Ms ELLIS - Yes, and they can keep working. They can have the treatments at home and keep working. The cystic fibrosis clients out of that hospital-in-the-home program - the research shows that they should not be coming into emergency for their treatment because of the risk to infection et cetera. It impacts on their quality of life. It has been a great success for those who've used the hospital-in-the-home program. There were 96 patients. The report the minister had, looking into that system, showed that it was very successful.

One of our other concerns is the decision on which areas are going to be cut. It seems that they are looking at the easy way out, that being hitting the front line first. We're not seeing the bureaucrats being targeted. We got the information from *Hansard* - this was an impossible number to get. We have written to all the CEOs and we asked the minister to keep us up to date with how many frontline positions versus how many bureaucrats. If the minister came out publicly and said she wanted to remove 150 bureaucratic positions, we would absolutely support that. That's where the efficiencies can be gained. Let us start there while we get the systems and contingencies down below. We have seen quite the reverse. We have seen that 126 frontline positions - this was late last year in *Hansard* - have gone, while we've only lost 69 bureaucratic positions. So 1:2 - it's all round the wrong way.

Dr GOODWIN - Later on in your submission you talk about the cuts to the IT employees - 42 - are they included in that 69?

Ms ELLIS - No, that was pre that announcement around the IT employees.

CHAIR - Just going back one step, under 3.1.1, you've said that the Tasmanian Government consistently asserts that these cuts will not affect patient care. Do you have evidence to the contrary? We've talked about hospital in the home in Launceston and you've given some figures around the savings as opposed to the costs there, so are there other aspects that demonstrate how these cuts have affected patient outcomes and delivery of service?

Ms ELLIS - There certainly is much research around in regard to delays in elective surgery, so for someone to be consistently waiting on the elective surgery list and not going that, when they finally get to hospital - in the meantime they have ongoing requirements for GP services, for analgesia or maybe physio if they need a knee replacement or knee surgery. They are then potentially have time off work during that time and finally, when they get to theatre they are going to have a longer length of stay, have more complex theatre and they are going to have more potential for risk of complications post-op. It just goes on and on and that research is grounded national and internationally.

Ms GORRIE - Especially chronic pain. Trying to treat someone who has chronic pain, then acute pain takes a lot longer.

CHAIR - Are you seeing this happening out there in the hospitals in the community?

Ms GORRIE - Anecdotally, I have said, I am thinking to myself, looking at the patients I see now, we are getting a lot more patients with chronic pain as well as the acute pain which is a lot more difficult to treat. If you have had arthritis for a long time and you have taken strong pain killers and you have surgery, what we would normally give you, we have to give you a lot more off and then start to ween you off it before you go home.

Mr ELLIS - It can be the result of waiting longer for surgery.

Ms GORRIE - Yes.

Mr ELLIS - What we see and obviously that is the community and those figures are again that it is quality of life at those figures. So the real effects of this in regards to real people and their health and their quality of life is not been measured.

Mr BRADLEY - It is probably too early to say as well because someone with a chronic problem with their hips who needs a hip replacement, they are going to wait another six months and it will cost them pharmaceuticals. In terms of chronic stuff it is probably a little too early to say. The Emergency Department had a few people who have anecdotally just turned up and hoped to get pushed up the list a little bit but we have assured them that is not going to help.

Mr ELLIS - With regard to bypassing the system, many of those who are elective surgery on the list are coming in now through the Emergency Department. I do have those figures in regard to the Launceston General, I think it was, that they are now seeing 35 to 40 per cent of their theatre list are emergencies which truly has increased quite dramatically. They are not true emergencies. However, because they are waiting so long on the elective list now, they are coming in and becoming emergencies.

CHAIR - Thirty per cent of their patients?

Mr ELLIS - Thirty-five to 40 per cent of the theatre list are emergency patients now.

CHAIR - What was that previously? Do we have a comparison?

Mr ELLIS - Sorry, I do not have that previous figure but it is significantly more because with the majority of theatre, normally we have one emergency theatre and four or five elective surgery theatre sessions. But we have started cutting down now at the Royal, 85 sessions down to 60. So that is 15 that equates to three surgery -

CHAIR - Three sessions?

Mr ELLIS - No, 15 sessions, 85 down to 60 sessions which is 15 half days. It is quite significant the loss in service of elective surgery and we are now seeing more of that, now that we have closed all the beds, elective surgery being cancelled more often.

CHAIR - Do we have figures of the amount of surgery that is being cancelled? We have to do a comparison. Obviously there are always surgery cancellations for a variety of reasons, either the patient is not fit or there an emergency come in or whatever.

Mr ELLIS - Again, we do not have that data. But what we see and what nurses are saying is that we know that because we know when the beds are full and we have patients banking up in ED waiting for beds. But in elective, there is no choice but to start cancelling elective surgery.

Ms GORRIE - Today I overhead it in the corridor - 'We will cancel, blah, blah, no beds.'

Dr GOODWIN - The worst-case scenario with the delays with elective surgery would be avoidable deaths. Is there any evidence of that occurring so far or is it still too early to know?

Mr BRADLEY - Too early to say.

Mr ELLIS - We do not have that data and it is too early because the real cuts began in the north on Christmas Eve. That is when we started closing the extra 20 surgical beds and the theatre starting slowing down and the real cuts started when we started Surg West to close around October, November in the north-west and at the Royal it has only been since November-December the beds have been closed and theatre has been reduced. It is going to start impacting a lot more and we are already seeing certainly the first impacts. But from the next quarter we will really start to see a huge impact. Normally over January it is a quieter time because the slow-down with elective surgery with people being away.

Point 2 talks about national health reform. Again, it is being thrust upon us and the time frame of that is 1 July this year. We do not believe the national health reform is going to improve patient care or people's outcomes. It is very much a governance and funding model as opposed to a quality of care model. What we are concerned about though, with the funding totally reliant under the national health reform, is activity-based funding. So the more you do the more funding you get. Task 60 per cent of the set fee to specific procedures and what we are very concerned about is how on earth we are going to rebuild capacity, the loss of skills and the loss of services and the loss of infrastructure. Some of our closed wards have already begun being moved into offices. All of the beds that have been closed at the Launceston General have been put off site and into storage. It is not short term; it is long term to be closing down the capacity.

When national health reform comes in and we need that activity to provide the funding we just can't suddenly click fingers and get the surgical theatre nurses back in again and all the people back in that we have taken five or six years to recruit. That is the area that has been hit the hardest.

Dr GOODWIN - Do you think that the beds that are being closed at the moment are not going to be opened in the short term?

Ms ELLIS - We have absolutely no indication in the short or the long term that they will be reopening all services. In fact from what is happening and what we are seeing we would say that it is very clear that they are not reopening these services or reopening the beds.

Mr HARRISS - Back to that point Ruth raised about the closing of beds having a negative impact, somewhere in your submission you mentioned that another government had claimed that was the fact. Our Government here says that it is not the fact, so one of them is wrong.

Ms ELLIS - That is quite ironic. While our Tasmanian Government is closing beds, when the nurses during their campaign around safe staffing in Victoria late last year closed the beds in going back to their safe staffing levels, the Victorian Government were clearly arguing that nurses are going to costs lives by closing beds, yet here our Government are directing beds to be closed and saying it is not going to affect patient care. We would say our Tasmanian Government is incorrect.

In regard to 4.1.2 at the back, appendix 4 in our paper was a submission we put forward to the Department of Health in May 2011 where we realised there were some significant issues around budgets going forward. In that paper of actual solutions and suggestions there are around 60 suggestions of how to save money in the Department of Health.

Only around 20 per cent of those have been implemented; the majority of them have not been implemented. They may be small things but built over time they are just making better efficient services. It is really disappointing to see that the majority of those suggestion or solutions have not been put in place.

CHAIR - Quite a few seemed almost no-brainers in some respect. You say about 20 per cent have been implemented but of those that haven't do you think there are any big-ticket items that you think really should be considered that can make significant differences to cost savings? For example, 2.5 implement a nursing clinical information system. I am just wondering about the cost of implementing that and then the savings that would create. Can you give us some information about that and any others that you think really should be progressed because they could have significant impacts, and also on patient outcomes?

CHAIR - Our whole IT and data collection and data integrity is very poor in the Department of Health - and that is submitted by the Department of Health. We have different systems. For example we have a system for pay and we have a system that empowers our system statewide. We also have a separate IT rostering system - Proac. They don't speak to each other so everyone has to do manual time sheets and it has to be checked from Proac manually. Then it has to be sent down and entered, rather than just being reconciled and speaking to each other, so that is a huge inefficiency.

Ms GORRIE - In mental health they have now stopped the introduction of the electronic database system. They are saying it is not just cost cutting but also the system they were looking at probably wasn't going to work. So you have a situation in Tasmanian mental health where it is all still paper-based, except for our help line. There is a whole lot of money that we could access through the Federal Government but you have to show statistically that you will use the money properly and where it can be targeted. The only way to really do that properly is through developing an electronic database system. Also that would bring everyone on the same level across the State, whereas now you have the north doing it this way and the south doing it this way, so it is inefficient and time wasting. I waste a lot of time doing paper work. I am on the industrial consultative committee and we constantly say that we believe this should be the priority 1 issue because it would sort out all the data and the statistics applications for Federal funding. It's just not going anywhere. Everyone says to me, 'It's a cost-cutting measure', but it wastes so much money; it should be a priority issue.

Ms ELLIS - The nursing information system is broadly used in other States - and we did put that in our State budget submission around five or six years ago. Rather than bringing in these restrictive systems, the current PAS system, which was introduced last year, is truly just a data system that does no more. Bringing in a whole integrated system would have benefited patients and outcomes, could have been used for research and evidence-based practice, would have decreased the length of stay. There would have been a whole range of improvements. It seems that the IT systems just don't meet the needs. There are some upfront costs, but the benefits are already proven in other States.

CHAIR - But you haven't done a cost-benefit analysis?

Ms ELLIS - In that State budget submission about five years ago we requested a trial in the north and the south. It was around $2.4 million to bring the trial in. We had the evidence base as part of the submission of the benefits of it.

CHAIR - Did you have any idea back then of what the cost savings would have been?

Ms ELLIS - I don't know the cost savings, but it was more relevant to quality of care; it wasn't measured in costs.

Ms GORRIE - In mental health we're missing out on a whole lot of Federal funding. I can't capture in a day the amount of work I do on a paper-based statistical system, whereas when I was working in the Northern Territory everything I did was on an electronic data system so people could get that information out of the system and submit it to the Federal Government.

CHAIR - So you're saying the additional money that the Federal Government made available in the last budget for mental health funding is what you cannot access here?

Ms GORRIE - Some if it, yes, won't be given to us because we don't have the ability in our statistics to show; you have to show in the statistics that this is the work you're doing in order to get the funding.

Mr WILKINSON - So, in short, are you saying that because you don't have the proper IT system in place you can't make application for funding from the Commonwealth?

Ms GORRIE - Yes, or we're not eligible to get it because it goes to a different section.

Mr WILKINSON - Do I also understand that you are unable to ascertain what your wages are each day at the end of the day because the systems aren't talking to each other?

Ms ELLIS - You could manually work out what hours and what your rate is, but you can't because there is no correlation at all. All we do is manually check. When someone does a handwritten time sheet, the nursing unit manager has to go to the roster on the system and check that they are the shifts that they worked. That could all be done electronically.

Mr WILKINSON - So if you had the proper system in relation to that, you would be easily able to pick up whether you were spending too much on overtime or whatever?

Ms ELLIS - Correct.

Mr WILKINSON - Therefore one would conclude that there could well be a significant saving if you had the proper IT system?

Ms ELLIS - Correct, and it would get rid of all the manual work.

Ms DRIVER - I have to fill in two time sheets every pay period because I have two separate job numbers. Instead of reading where I am, I have to manually write it.

Mr HALL - Is there a ballpark figure of the quantum of funding that we might be missing out on from the Feds in terms of mental health?

Ms GORRIE - I can do more research on that through liaising with the Medicare locums. I would sometimes work on a helpline at night. I can go on the DMR and get information about inpatients but because there is no database, I can't look at risks if I'm assessing someone in the south. It's such an inadequate system where you can't support the client properly because it's basically paper based. You can imagine how much information is required to support safely your Mental Health client. If it's all on an electronic system, everyone can access it and add to it and you would get such a better safety net. Things get lost all the time with a paper-based system.

Mr HALL - Is there a ballpark figure on the quantum that we might be missing out on through having these inefficiencies?

Ms GORRIE - You should ask Mental Health because there is currently a ban on ORS because we are so frustrated with them and we want them to bring in this system. They are saying we are missing out on millions of dollars worth of funding.

Mr ELLIS - Then it has to be transferred into the system by hand.

Mr HALL - Yes, so it is going to be tens of millions of dollars.

Mr ELLIS - We can try to get that information -

Mr BRADLEY - From an emergency point of view, there is some money floating around that I know of to introduce a new computer IT system into the emergency departments within the State as well. That is Federally funded and it is at risk of being lost through bureaucracy slowing us down. This would increase the ability to see if we were meeting the triage target times on the day.

CHAIR - Patient data management?

Mr BRADLEY - Yes, it is. We can type our notes into it and we can take clinical photos so that it could all go into the patient's record. We can send the GP letter out with the click of a button, instead of my sitting down, writing notes, taking time, where I could be getting on and seeing another patient. There is Federal money here at the present moment to look at a new system, a system discussed at high level, the emergency care network, and from the best of my knowledge it has been told to hold on.

CHAIR - What if we had a system that allowed you as a clinician, when a baby is born, to sit at the computer and you put in all the data once and you press the button and it gets spat out in every direction it has to go. You do it once; you do not write 13 times on 13 different documents.

Mr ELLIS - We are still doing it 13 times. The system has not improved

CHAIR - Yes, I know. They are still dreaming, like I used to. You could potentially manage with fewer nurses because they would be out there doing the patient care as opposed to writing to 13 places.

Mr BRADLEY - I do not know about fewer nurses. I think we will always need them.

CHAIR - Not necessarily fewer but you would be more effective and more efficient in what you were doing.

Mr BRADLEY - The technology is out there. I can come and see you, take your history and put it straight into the computer. I can ask for bloods or the X-ray all from the press of a button. I do not have to fill out three or four forms, then write to GP and say this is what I have done. So it is going improve the communication between us and the GP. It is going to improve the patient care. Everyone is going know what everybody is doing.

CHAIR - Are you saying there is Federal funding available for these systems if we can demonstrate that we are ready to put it in place?

Mr BRADLEY - We have money that has been allocated.

CHAIR - What is happening with that money?

Mr BRADLEY - It is still in liaison.

CHAIR - What is 'liaison'?

Mr BRADLEY - To the best of my knowledge there is some bureaucracy going on within the DHHS where the people involved to get this system up and running have been told not to talk to *[inaudible]* for the moment.

CHAIR - Because they do not want to spend the money?

Mr BRADLEY - To try to get them all to talk together. The money is there and we are at risk of losing this money.

CHAIR - So it is Federal Government money and they will take it back if we do not do it?

Mr BRADLEY - It is to do with the emergency care networks.

Mr WILKINSON - Are you able to say how much money that is?

Mr BRADLEY - I can't remember, but in the millions.

Ms GORRIE - Ways to put more money into the mental health budget from Federal funding is credentialing or charging the Medicare scheme when our psychiatrists do mental health assessments because we always write to the GP to give feedback. As allied health professionals, with a lot of the work that we do with clients in mental health, if we were credentialed we could claim that on Medicare. If all the mental health community nurses were supported to become credentialed then we could link into some of the Federal money that is coming to GPs to look after the chronically and seriously mentally ill. We can go and do the home visits, do all that work and keep them out of DEM and liaise better. But when I keep bringing this to the industrial consultative committee meetings, there was one person working on it, they were off sick, so no-one has been working on it but this could bring in millions of dollars worth of revenue. All of us would like to do it and I would really like you guys to run with that one because it can save our budget.

Mr ELLIS - So for credentialed mental health nurses, for every assessment they do, which they do as part of their work anyway, the department would receive Commonwealth funding for each assessment that they do.

Ms GORRIE - Every time a psychiatrist sees a client, you could charge Medicare for that. It is ridiculous.

Mr ELLIS - So paying the Department of Health for all those services.

Dr GOODWIN - So we are not getting that money?

Mr ELLIS - We are not getting any of it.

Ms GORRIE - There is one person working on it.

Dr GOODWIN - Is this an IT person or another person?

Ms ELLIS - It has to be a professional person to work on the credentialing of the model. We actually had to bring in and actually get the mental health nurses credentialed for the program, set it up and get the billing - there would be a whole range of systems.

Ms GORRIE - And the psychiatrists - I mean, it wouldn't be very difficult to sort out. I keep saying why isn't this a priority issue because this would fund a lot of mental health services especially for the seriously mentally ill because that is where a lot of the Federal money is - for serious mental illness. It would just save so much money.

Ms ELLIS - And one of our solutions is that we should be accessing every single piece of Federal funding available that other departments of Health in other States access and we are not. We are very poor at accessing potential funding.

Mr WILKINSON - Do you know what funding in total Tasmania is getting comparing that with other States and then putting it on a per capita basis?

Ms ELLIS - You may have to ask the Department of Health that question.

Ms GORRIE - It would be good to ask them about the IT.

Mr HARRISS - Where in Australia is such a high level of integrated IT infrastructure working?

Ms ELLIS - In most States - Queensland, South Australia -

Ms GORRIE - The Northern Territory.

Mr BRADLEY - Melbourne has it all.

Ms ELLIS - The nursing clinical information systems are pretty much broadly spread across the country and then from that nursing clinical information that goes straight to payroll. Everything is just integrated.

Mr WILKINSON - Which hospital in Melbourne?

Mr BRADLEY - I think it may be the Northern.

Mr WILKINSON - Is that what it is called?

Mr BRADLEY - I am not entirely sure.

Mr WILKINSON - It is called the Northern Hospital?

Mr BRADLEY - I think so.

Ms ELLIS - Queensland is one of the better States for data integrity and collection and they can react and actually change a lot of the care around that, too.

Mr BRADLEY - Most doctors were filling out a time sheet in Queensland 10 years ago.

Dr GOODWIN - Are there off-the-shelf packages?

Ms ELLIS - You wouldn't have to reinvent the wheel, there certainly are, so the one that we proposed for that budget submission there was an off-the-shelf program they could have bought. Someone came down and gave us a presentation.

Ms GORRIE - And it is the same in mental health because there are already programs available in different States but then they tried to modify some program for here and it hasn't really worked. It is just crazy - I don't see the sense in it.

CHAIR - It's not a priority obviously. Can we just go on to the other ones -

Ms ELLIS - Could I take the opportunity and actually bring back to you exactly which ones we see as a priority because I haven't got the key priorities running, but I am happy to bring that back.

CHAIR - The ones that haven't been implemented that you see as priority?

Ms ELLIS - As a key priority, yes.

CHAIR - That would be great.

Ms ELLIS - I will put that on my list of things. We could probably then about risks and clearly, as I mentioned in the opening, before any change, risk management forms and risk must be done and we found that very difficult to get that information and to actually be comfortable with the identified risks being clearly mitigated and they haven't been. One of the clear risks in ED is overcrowding as is a potential for increased aggression from the community towards nurses because they are going to be backed up there, sometimes for days, on trolleys waiting for beds. Everyone gets very frustrated in that type of environment. Overcrowding also leads that sort of environment where people are pretty crabby with the care they are getting or the waiting times, et cetera, and get more and more frustrated so that is the sort of verbal and physical abuse that is occurring. We

are seeing certainly a trend of increasing physical abuse against nurses as well. In fact we have that in our submission to the Drug and Alcohol and Violence committee that is still sitting.

Dr GOODWIN - Yes.

Ms ELLIS - OH&S is a very big concern for us. We have not seen any risk mitigation that is going to address that and in fact one of the hospitals still hasn't got a de-escalation overcrowding policy. They have nothing ready in place when we know this is already happening on a daily basis. Our WorkCover stats that we have only recently received are quite damning on the Department of Health. Between 2000 and 2010 the number of claims for all insurer segments decreased 19 per cent, however in the State services only 1 per cent over the same period. We are also seeing that most claims occurred in the departments of Health, Education and Police. We are seeing that the high number of claims in the Department of Health maintain a high incident rate across consecutive years and the departments of Health and Education have the highest total likely costs of claims average - 2007, 2008, 2009, 2010 - so as an absolute trend the Department of Health are not dealing with their OH&S issues. The injuries reported from the Department of Health show that most workers injured are registered nurses, special care workers, personal care nursing assistants, ambulance officers and paramedics. They are the majority of people getting affected by the increasing aggression, the injuries, the poor systems and the lack of clear OH&S risk mitigation resulting in the State Service's performance being poorer than other insurer segments. The State Service has been identified as having a higher claim frequency per FTE, a higher lost-time claim frequency per FTE, a higher weekly benefit continuance and a higher average claim size for all claimants. We know that OH&S is handled very poorly. We are very concerned going into the future around a safe working environment with the pressures of not only the building but the closure of beds and the situation particularly in the ED and the community, where we are still seeing some of our nurses going out into the community for a palliative care visit for someone they have never met before.

Ms DRIVER - Because they're cutting back frontline case managers, all the community teams had to lose two full-time case management positions - and there are more cuts coming. You have an increased case load and you can just imagine the flow-on effect. You also have clients who don't have case managers because there are no case managers there. Because of the closure of ECAT, which was Federal funding, and its merging with our crisis teams, we have an ever-expanding interim support list. You have a situation where you need to get all this done. We have asked how we're supposed to change our model of care or how we're supposed to do our case management differently to allow for the cuts. The risks for staff and clients and their families are going up and we're seeing more presentations to DEM, longer waiting times in DEM and more people being discharged earlier because there is more pressure on beds. There is a lot more bed blocking now than there used to be.

Ms ELLIS - In addition to that, we've written to the Premier seeking indemnity for nurses who are working in this environment. We have identified many risks that haven't been mitigated. We have sought that nurses, particularly at the front line with the reduction in services - the majority of people being removed from the system are nurses - that we have a clear and automatic indemnity but that has been refused. We are continuing under the MD8 process, which means a committee including Treasury will consider the claim.

We've had nurses refused before from being granted indemnity. A recent one, which was a coroner's case, was granted conditional indemnity. The time frame was that we wrote in October and we received it two weeks ago that she had been granted indemnity. She's been in front of the coroner's court already.

CHAIR - Shouldn't precarious liability cover this?

Ms ELLIS - No, precarious liability does not cover it. It is not the precarious liability in the national standard. It's talking about civil liability and appropriate insurance. The Government is a self-insurer. One would hope that precarious liability would be accepted, but we have had another case where they said it was outside their scope of employment and they wouldn't cover this person.

CHAIR - Because they were acting outside the scope -

Ms ELLIS - Well, they weren't; that was their discretion. It's discretional. We will be writing back and saying, 'We see foreseeable risk, that there is going to be some serious patient adverse outcomes coming up in the near future'. We want to make sure nurses are protected, and they're not at the moment. ANF members have their own insurance scheme but for a few who are not ANF members remain potentially at the will of this discretional committee under Ministerial Direction No. 8.

Ms DRIVER - To add a bit more fuel to this, for example we just saw an orthopaedic nurse sent to relieve in maternity. She's not a midwife so therefore she can't work as a midwife but if you look at the scope of practice you think,' Where's the decision making there if someone is bleeding or what if a midwife going to relieve in psych?' These are all recent cases. I get around the hospital a lot and I see people and say, 'You don't normally work here' and they said, 'No, I've been sent relieving'.

Ms ELLIS - That's an issue of the current surplus clients when they are closing beds. They look at nurses as 'a nurse is a nurse is a nurse' and we all know that a nurse is not a nurse is not a nurse, as a midwife is not a midwife. You can't suddenly move someone from an acute surgical ward and put them into, say, ED and expect them to be fully functioning. There are quite speciality areas now that nurses work in and they've been working there for years. That is their chosen career pathway but are told, 'Sorry, we're closing the service down. You're a nurse so we'll redeploy you'. That is where we are concerned around people's potential scope of practice and duty of care.

CHAIR - Are we seeing more instances of nurses on stress leave at the moment?

Ms DRIVER - Yes. I think the figures are in that document I tabled. We got these figures from freedom of information - nurses' workers compensation, the 197 for the last calendar year, of those 30 were workplace stress. That is pretty high.

CHAIR - How does that compare with previous years?

Ms ELLIS - This is only through Freedom of Information; that information is not freely available.

Ms DRIVER - And we're only at the start of this stress.

Ms ELLIS - Look, there's no doubt morale is absolutely rock-bottom in the hospitals. It's very, very -

Ms DRIVER - Well, everybody is just looking around and thinking, 'Is it me next? What's next?' Just keep your head down and -

Mr WILKINSON - It's not only that, is it, because somebody recently told me that in Victoria there are a lot of nurses saying, 'Tasmania - because of the uncertainty I'm going elsewhere', and only last week one of the Melbourne hospitals put on six Tasmanian nurses, or so I understand. You'd have that as well, wouldn't you?

Ms ELLIS - There's an exodus. We can see from our membership - we obviously track where people are going, and we are losing so many nurses at the moment. Thirty nurses in the last two months we've lost. They've transferred to other branches so they're working still. We have about 20 who are just not able to find work anymore so they're the ones that you see in the media that have gone to work in other jobs, in Woolworths or wherever they can. These are a lot of the young nurses who have finished their 12-month Transition to Practice program and are told, 'Sorry, that's the end of that, there are no more jobs for you after that' - and yet they have mortgages, they have rent to pay and they have obligations. They have to work and it is quite unheard of that we are seeing this. Other States are crying out for nurses and of course -

Dr GOODWIN - Once we lose them we'll find it difficult to get them back.

Ms GORRIE - We're losing good specialist experienced nurses because they go interstate and they don't come back.

Ms DRIVER - And the DHHS has spent thousands of dollars recruiting neonatal nurses, only for guys to be put on fixed-term contracts finished -

CHAIR - How many in that case are you aware of in that speciality area, for example?

Ms DRIVER - In October I wrote a letter to the CEO and Executive Director of Nursing about concern for 13 nurses that were on fixed-term contracts that were expiring in December -

CHAIR - December just gone?

Ms DRIVER - Yes, just gone. We were already seven full-time equivalent positions down so if we'd have lost those 13 that would have meant 20 nurses down. It has finally taken them until this week to advertise four full-time positions for those 13 nurses and yet we've just had three resign in the last fortnight, so we're down again, so you're just constantly trying to patch up as you go along.

CHAIR - So will the 13 nurses need to reapply for those four positions that have been advertised?

Ms DRIVER - Yes, because those four positions are permanent which involve a different -

Ms ELLIS - The 13 are on fixed terms so they have to apply for those positions. This is after the Department of Health sending international recruiters for senior nurses over to Ireland and South Africa in the last couple of years, and that was the targeted group. They were taking theatre nurses and neonatal intensive care nurses and they are the ones now - we have lost theatre nurses left, right and centre because -

CHAIR - Has it been a deliberate decision to actually reduce the number of theatre and intensive care nurses?

Ms DRIVER - It has been a carte blanche - it is like no employment for each speciality.

CHAIR - It's indiscriminate, that's what you're saying?

Ms DRIVER - Yes. We, as ANF members, had to actually knock on the door of the CEO and say, 'It's not on. You can't just let these girls go'.

CHAIR - Have we actually lost any of these people who were specifically recruited, who came as a result of those visits to South Africa or Ireland?

Ms DRIVER - We have lost one who has had to move because her husband got work interstate.

Ms ELLIS - But certainly we have lost quite a few mental health nurses although they may not have been internationally recruited. We also have quite a few nurses working on 457 visas and they're pretty much all being removed because they are on fixed terms, so most of them have had to get jobs elsewhere to maintain their sponsorship and a lot of have gone into aged care in Tasmania just to stay here. But they were speciality nurses - ICU nurses - who are on 457s and now they're in aged care, just to keep -

Dr GOODWIN - These were the internationally-recruited ones?

Ms ELLIS - Yes.

Dr GOODWIN - Who because they were on fixed-term contracts have now gone into aged care.

Mr BRADLEY - From my point of view, I am also here as the President of the Tasmanian College of Emergency Nurses. We provide education to nurses within the State to further their skills and just in the last couple of weeks we have had three of our nurses move interstate, and these are people that were trained up to resusc levels so they're not junior nurses, they're senior nurses that we're losing and -

CHAIR - Whey are they leaving?

Mr BRADLEY - Anecdotally they've said, 'I'm after a bit of security'. They were probably going to get jobs or have their fixed-term contracts turn into permanency but they are just not sure.

Ms ELLIS - It is the insecurity at the moment. The people leaving just don't want to risk staying here at the moment because there are no guarantees - and there's no guarantee of more cuts not coming in around the corner.

Mr BRADLEY - They may have been planning to go but this has made them go.

Mr WILKINSON - In relation to percentage or numbers, are we able to say in DHHS how many non-frontline employees there are as opposed to frontline employees? This is probably too simplistic to say but I will say it anyway. It seems to me that what needs to happen in order to carry out the medical necessities that have to be done in relation to any State, you need your doctors, nurses and the other people who can make people better.

Mr ELLIS - Yes - 24 hours a day.

Mr WILKINSON - Yes, that's right. Therefore, what you do is say, 'We will endeavour to have those people involved and we'll take our cuts from elsewhere', being the non-frontline people, and from there you can then see who you need and in what capacity you need them. But it seems to me to be the other way around at the moment. Somebody once said to me that law would be a terrific profession if you didn't have any clients. It seems to be the same thing here - a hospital would be a terrific place if you didn't have any patients. I think they've got the cart before the horse - anecdotally.

Mr ELLIS - We would certainly support that. We do see that as the very easy way, the very quick fix, to close services rather than fix up the system and make it more efficient. As to the bureaucracy, you're quite right, we probably do need some support staff around that patient care unit as well, but certainly there is a monstrosity of bureaucrats in Davey Street, in Murray Street, in Bathurst Street, you name it - and that is just in Hobart.

Mr WILKINSON - Do you know the percentage and numbers of those?

Mr ELLIS - There would be a grey area. It is very hard to put a definition of exactly clinical because somebody who may assist and support clinicians does not have direct patient care. So there would be a grey area but they would be definitely easy frontline, easy nowhere near patient care, not even understanding the patient background in health care, so there would a grey area. So that is how you would have to look at the information. We have tried to do that in mental health.

Ms GORRIE - It is very hard because we consider administrative staff in our community teams as frontline staff because they are in the reception area and are part of the treating team. There is also an issue of accountability for some of the decisions that are being made or not being made. That is why a lot of people get disillusioned. I know two people from interstate who are going back because they said there is just no sense to what is happening here. The two things I've talked about, IT and credentialing - if you're fair dinkum you just really, as managers, go full-on in that area and there is just nothing to show for it. There's just lack of faith and accountability as well.

Mr ELLIS - We would also say we need a very clear work force plan for our whole system. We need to know how many doctors and nurses we need in the future, what we need and what we're going to look like in five to 10 years' time because we have an ageing work

force. Nationally, the research is there for an absolute crisis in five years' time, not only in Tasmania. We will be the first to be hit because we have the oldest average age of nurses working in Tasmania and midwives, the oldest in Australia. So we're going to be the first to be hit with this huge shortage.

Mr HALL - We knew that.

Laughter.

Mr ELLIS - But it's clearly something we've been calling for, a clear workforce plan, because then we would know how many graduates we absolutely need in this State for the ongoing succession and the modelling of the right skill mix and nursing.

CHAIR - But Neroli, it's also fair to say that you can't afford to have a gap for any period of time where you don't have any graduates coming in because ultimately it's going to get to the point where, if they all retire at once in a big block again -

Mr ELLIS - It is not only the graduates but those finishing the one-year graduate Transition to Practice program - we do not keep them on. That is also our new replacement pool for the more senior ones as they retire, so they're the ones we're giving the chop to first. We are not putting on nearly as many graduates but we're also terminating our graduates who complete their first year. There are no job opportunities to speak of for them.

Dr GOODWIN - Essentially you're saying we have not done that workforce planning and we will be competing with the rest of Australia, which is facing similar problems?

Mr ELLIS - Absolutely, very clearly. We now have 1 000 Bachelor of Nursing students at our university. Around 300-350 graduate each year and of those this year, we now have our graduate figures and these have come from the hospitals - and that is on the sheet too - the majority have been employed on part-time contracts to enable more of them to work, but it is down to 0.6 FTE, which is only three days a week which makes it very hard to maintain a family and/or rent when you are employed with those small numbers.

Last year the 2011 intake was 169.5 full-time equivalent graduates. This year to date it is 57.8 so, despite the fact the minister is saying up to 98 people, you can see the line above that says 'graduate numbers employed' is 71 but full-time equivalent hours is 57.8. That is less than one-third of graduates from last year; that is 58 FTEs out of 300 graduates. It's very sad to hear all those stories of graduates who are desperate to stay in Tasmania near their families. They may not all be young but the majority seem to be the ones who have left because they're the most flexible. We have lost so many of our young graduates now who didn't get these positions. The process was so poor, to leave them waiting so long so that the other interstate recruitment processes had all closed by the time they were finally told, 'Sorry, we're going to be dropping numbers quite significantly'.

Ms DRIVER - And yet I got three texts yesterday - on my day off - asking me to go to work. There's work there.

Ms ELLIS - We'll come to that; we'll come to overtime.

On top of page 11 it says that nearly one in four Tasmanian nurses are aged over 55 and only 3.3 per cent of our nurses are under 25. Again, workforce planning is absolutely essential so that we know exactly how many graduates we must be taking every year to replace those who are retiring.

Dr GOODWIN - It says here, Neroli, that Health Work Force Australia has done some modelling for each State.

Ms ELLIS - Yes, and it was presented to the MINCO, I think in August, and sent back by the ministers because they didn't like what they saw. It was reported to us that they didn't like the numbers that were being modelled of how many we would need, so they sent it back to Health Work Force Australia. It still hasn't been released. I can tell you, we've been holding out for that because that will identify how many graduates we must be employing in Tasmania to meet our workforce needs in the future.

Dr GOODWIN - Is that something you can send back and say, 'Do it again'?

Ms ELLIS - Health Work Force Australia assured us, when we met with them federally, that they would not be changing the assumptions. They were certainly prepared to look at differing scenarios but not the assumptions. We would have faith in Health Work Force Australia but that's reliant on the MINCO and the ministers to release that information publicly.

Mr HARRISS - Why is it reliant on the ministers to release it?

Ms ELLIS - Apparently the MINCO is where they determine - it's their report; they commissioned it. It's like any report, I suppose - it's in Parliament until it's made public.

Mr HARRISS - Somebody else could commission Health Work Force Australia to do the same work.

Ms ELLIS - Yes, it's a government body. I think it's a Federal Government statutory body.

CHAIR - Does the Australian Institute of Health and Welfare do this sort of work?

Ms ELLIS - They do, but they just did the status of how many nurses in the State, what's the scenario, what sort of speciality, where you are employed, what is the ratio of FTEs per 100 000 population - but that is usually four or five years out of date so it's not relevant to making decisions now.

CHAIR - The College of Midwives used to do a bit of work in this area looking at midwifery work force issues. I don't know whether the ANF or the Royal College of Nurses do anything like that.

Ms ELLIS - There are about 280 000 nurses so the data we are reliant on is when people reregister each year. You need access to correct data to do it properly. The College of Deans has modelled it and that's why we have an increase in Commonwealth-funded nursing positions in Tasmania. That was based on modelling.

Mr BRADLEY - Certainly the College of Emergency Nurses is working towards safe staffing documents as well. We are working nationally to try to get minimum staffing levels for emergency departments.

Ms ELLIS - I will move on to overtime. The results of this poor system and the fact that we're not employing - we have 900 nurses on fixed-term contracts, so the whole employment system - it takes around three months to employ somebody in the current Department of Health in a permanent position. By the time they go through the interview, the selection report goes through all the channels, it goes to HR and you are finally notified, it is a three-month process. Nurse unit managers can't wait three months to put someone on the roster; they usually need someone straight away, so they put people on fixed-term contracts. Unfortunately it has been a way around the broken system. Most nurses come into the system on fixed terms and over time they become permanent. The result of that, unfortunately, is that we have around 900 nurses on fixed-term contracts out of 4 200 nurses, so around 25-30 per cent of our nursing work force are on fixed-term contracts.

Dr GOODWIN - Neroli, do you know many of those have already lost their jobs?

Ms ELLIS - We know from these figures the exact number of nurses that have gone. There are 108 acute beds that have been closed to date, there have been five theatre suites closed to date, and the nursing positions lost to date are 119 full-time equivalents.

Dr GOODWIN - Would most of them be on fixed-term contracts?

Ms ELLIS - Yes, because no permanent nurses lost their jobs; they have been redeployed. They are all fixed terms. That is 119 but there are 900.

Ms DRIVER - But they might have been on three years' worth of fixed term.

Ms GORRIE - Is this in community as well or is this just hospitals?

Ms ELLIS - This is just hospitals. So it is not mental health.

Ms GORRIE - So you have not covered the community.

Ms ELLIS - Regarding the impacts to the community, apart from mental health, in the primary healthcare setting we have not seen services close down yet.

CHAIR - We were told they were not being dealt with at the moment, though.

Ms ELLIS - No. They are on the second stage, I think.

In addition, we have seen agency nurses still being employed. They have reduced them quite a bit and many of the theatre nurses that went were either international nurses or agency nurses and obviously we would rather see permanent staff. In fact they are still now employing because we have so many vacancies. The Royal at the moment has around 90 permanent vacant positions and yet we are working pretty much double shifts or overtime on a regular basis.

If I can take you to 5.1 - these are the figures I have got out of the Freedom of Information - the overtime for nursing only for the last financial year has increased from the previous one to $6.8 million of overtime, and I can assure you that nurses do not want to work overtime. You only work overtime if you can see your colleagues coming on for either night duty or an afternoon shift and they are going to be short; someone has to stay back. The have tried casuals, they have tried pool staff and they have tried part-time staff doing extra shifts and 17 hours straight and it is not cost effective to do double shifts.

In the last calendar year, 2011, 1 189 double shifts were worked. That is not the overtime, that is just straight double shifts, working 17 hours straight and, of course, when you do a double shift you are on overtime after eight hours, you are on overtime for the rest of it and often you were rostered to do the next shift the next morning as well. So you have to be paid for that and they also have to pay someone to come in and backfill that shift. It is a huge waste of money and not a safe, sustainable staffing model to be relying on double shifts which we are on a regular basis.

The report I have here is that for the last quarter 72 double shifts were worked in STAHS, 41 in the north and 45 in the north-west. We do not have the most recent figures. But we have vacancies left, right and centre. We are turning graduates away. We are terminating fixed-term contracts, those who have done the 12-month program. We are not employing because of this business control and this business review, a bureaucratic process that is making it almost impossible to employ. So the only result is double shifts to cover the shortages or to put people on more fixed-term contracts which is in breach of the State Service Act which is why we are in this mess.

Mr WILKINSON - Double shifts cost more too.

Ms ELLIS - Of course they do and there is so much research that shows that if you have done 17 hours straight, you are working at a blood alcohol level of 0.7. On top of that it is poor patient care. It is poor for the nurses because they are going to have to stump up and work the next shift the next day after working 17 hours the day before.

CHAIR - Even if you have that eight hours break in between, you are still stuffed when you come back. I have been on the other end of the phone when they beg and you have been there, so you know. You say yes, even though it is your daughter's birthday or something.

Mr WILKINSON - In relation to that, and I mentioned it last year, I have an anecdote about a person who was working a full shift and then had to stay on because of an emergency situation. He was told he was needed to work a double shift and he said, 'I am unable to because I have to work the following morning'. They said, 'No, you have not'. He said, 'Yes, I have' and said that on a number of occasions and they kept saying, 'No, you have not'. After working three hours into this double shift, they said, 'Yes, you are working tomorrow morning, so you had better go now'. He left and went the following day and therefore was paid not only for the shift that he had to work but also the extra for the three hours plus the double shift or overtime, whatever it was.

Ms ELLIS - He did not even have an eight-hour break.

Mr WILKINSON - That is right. Would that be sorted out too by that better IT system where a person could just plug in to see shifts, to see costs et cetera or would it not?

Ms ELLIS - The best system is obviously on the roster to identify the roster shortfall. At the moment, as an example, the Royal are putting out rosters with two to three roster shortages nearly on every shift because they have cut back the full-time equivalents, they have cut back the recruitment so the rosters are coming out with huge gaps and there are the shortages. The instructions have been not to fill those out of casual and pool, to wait for the day, that morning at six o'clock to call people in for those two vacant shifts, which we know is impossible to get the right skill mix, in case somebody somewhere may be spare and can be redeployed to that position for that one shift - somebody from somewhere else - which rarely happens because we are 100 per cent occupied now. The culture has to change. The HR system is really contributing to a range of issues around satisfaction and patient care.

Mr WILKINSON - In summary, also forgetting about those main issues which they are, the patient care and work satisfaction, if it was done properly there would be a cost saving in the end by employing the proper people.

Ms ELLIS - Absolutely, and better patient care because you have the right skill mix. If you get the right skill mix you are not relying on potentially taking the only person who you can get which might be more expensive, an experienced nurse rather than a junior nurse.

Mr BRADLEY - Certainly DHHS advertises on the website that it is family friendly, it is a place where you can get that work-life balance. It is not what I moved there for.

Laughter.

Ms ELLIS - The other issue is the nurses who cannot take annual leave. There is not enough relief factor and budget for the relief factor to enable nurses to take their full entitlement of annual leave so we now have a liability of accrued annual leave of over $6 million sitting there so there is *x* number of nurses with huge amounts of annual leave who cannot take their annual leave. They can't take their annual leave let alone the accrued annual leave that they have. We see annual leave being cancelled because of the shortages at the moment. We have had examples certainly at the Launceston General and at the Royal of annual leave being cancelled more recently because they are so short.

CHAIR - I thought there was a policy across the whole of government about annual leave accrual, that you were told you had to take leave if you got up to a certain level.

Ms ELLIS - With long service leave you can actually lose it if you don't take it when it has accrued but the problem is that nurse managers can't roster you off on annual leave because there is just not enough nurses to do that.

CHAIR - So they are breaching that policy - not through actions of their own.

Ms ELLIS - They breach the award as well because the award states that after six months you should be able to take your annual leave, so it is constant, and the nurses don't want to be accruing this leave because they want to take it. We are saying in our State budget

submission this year that we want to see the relief factor increase and funded because it is just not enabling nurses to take the appropriate amount of annual leave each year.

CHAIR - But if you weren't rostering with gaps then the chances of knocking out a few of them and people being able to take leave would almost resolve itself to a degree, wouldn't it?

Ms ELLIS - If you had a full complement of staff and a full replacement factor you should be able to roster three FTEs off in any roster period, which is a month, and that would be distributed over the year so you would know then at the beginning of the year you should have enough nurses and everyone could have their leave. However, nobody takes the full five weeks that they are entitled to, usually they can only take two or three weeks, so all of a sudden you start banking it. It is about the relief factor and it is about the budget. It is truly about the budget that they can't take it. For nurses to have their leave cancelled they get no compensation and they come back to work. That is going to fill the roster shortages but it is not going to help the nurse who then hasn't had leave and then potentially sick leave is increasing - and sick leave is increasing.

Mr HALL - In your submission have you got the number of redundancies which have been offered in the hospitals recently? I understand there has been a $20 000 package.

Ms ELLIS - Yes, there is, that is State Service policy across the whole State. Anyone who is identified as surplus has six months to be redeployed but if you say straight up as soon as you are identified as being surplus, 'I'm out of here, I'll take the redundancy' there is an incentive to go early and the State Service management office has made that sort of arrangement. For 2010-11 we have redundancies of 38.78.

CHAIR - When was that to, Neroli?

Ms ELLIS - Sorry, that is retirements. Voluntary redundancy, zero.

CHAIR - When was that?

Ms ELLIS - It was for the 2010-11 financial year it says here.

CHAIR - Perhaps it did not start until after that.

Ms ELLIS - Correct.

CHAIR - You do not have any up-to-date figures on that?

Ms ELLIS - Anecdotally I could say less than five and also they were actually refusing nurses to take the WRIP, Workplace Renewal Incentive Program, which the teachers got to retire early and be replaced by a more junior person - a less expensive person - and nurses will be refused that WRIP. So even if you want to leave and make the most of those incentives there were some nurses that could take that. One was a school nurse and she is the last school nurse in the State, we have no school nurses left in our State due to budget cuts as well.

Mr BRADLEY - Certainly one of the big things about being a nurse is you are supposed to professionally develop yourself every year and at present all conference legal and non-essential conference legal has been outsourced. So a nurse practitioner who needs to keep the professional development going on must get 70 points per year. To be able to get to some of these conferences I am self funding myself just to get the time off from work and go to them - if it is not essential then I cannot go.

CHAIR - Could you go if it was essential to maintain your registration?

Mr BRADLEY - Well, they are, yes. CPD - 20 points just as a nurse and another 10 as a nurse practitioner. It is very difficult. We have the College of Nurses conference here in Hobart this year and we were hoping for a big presentation from Tasmanian nurses but we are not going to be able to get the time off let alone the funding for it. It is very difficult that way. Certainly it was demonstrated in the Leading the Way document - and that was quite an expensive document - nurse practitioners would have better outcomes in care, but apparently there are only seven in the State. The stuff has been done we just need implement it, to be getting the figures right and putting people in the right places at the right time. Certainly the college has recently had a course up in Burnie, a trauma nursing process course, oriented to junior nurses to get them skilled up in the care of a trauma patient. We have had to cancel it because only four people put in to go and do the course. Was that because they could not get the time off? I have not been able to find out because I only just found out this week that the course had been cancelled. But my suspicions are there that that is why people are not going because they cannot get the time off work to do these sort of things to professionally develop themselves.

Ms ELLIS - There is also responsibility on the department as well to ensure that nurses have the appropriate professional skills and we have a policy out now, particularly in light of the Bruny Island issues, there is a new policy from departments to state that nurses working in a rural area with minimal support must have done an emergency nursing course. They are not allowing and actually providing that and not providing the time. There are about five nurses on Bruny, but only two of them have done that course and we keep pleading, the nurses are requesting to do the course to ensure that they are compliant with the policy because they could be in breach of the code of conduct if they are not compliant with the department's policy. So could the managers because we have actually requested that and yet there is no money so there is no training or professional development.

CHAIR - The same applies to the west coast, doesn't it?

Ms ELLIS - Yes, correct. I will skip through this a little bit because we have touched on quite a few things but only on the edges - 92 permanent vacancies at the Royal. If we go to point 6 and the impact on service delivery to conclude some of the real examples of what is happening in emergency nursing and some of the other areas.

There is no doubt that the closure of beds is impacting immediately on the emergency department with not only access to those beds but it is now impacting on ambulance ramping and we are seeing increasing ambulance ramping. LGH, which traditionally had no ambulance ramping 18 months ago, for the month of January had 60 incidents of ambulance ramping. It has been reported to us that it is not uncommon to have five ambulances ramped at the Royal ED. We now have paddy wagons ramped with mental

health clients or clients unfortunately who are needing security and restraint, being ramped also outside the Royal ED because there is nowhere to put them.

CHAIR - I saw the minister on TV the other night and there had been no ramping at the LGH.

Ms ELLIS - The day that she said that I went and counted the book and there were 60 incidents at the LGH.

CHAIR - So how do we get to the truth of the matter then, Neroli? I was watching the news that night, and I think that you were on the news that night, -

Ms ELLIS - I saw the media release and I went straight down to say let me have a look at where they have been ramped and I counted them up personally. There were over 60 ambulance ramping episodes in January.

CHAIR - So does it come down to a definition of what ramping is? Was the minister using some other measure or why do we get this discrepancy here? We have the minister saying there is none, but there is a book of evidence that says there were 60.

Ms ELLIS - Sixty ambulances then and the paramedics actually document, in their book, the time they start ramping and the time that they actually can discharge the patient to emergency. So it's clearly there.

CHAIR - How long would some of these ambulances ramp for?

Ms ELLIS - Sorry, I just looked at the incidents because I was racing through after hearing her release.

Mr HARRISS - Which month was that?

CHAIR - January.

Ms ELLIS - That was last week - year to date January. There have been 60 already and yet the minister was openly, publicly stating that there is no ambulance ramping.

CHAIR - She said there was none; zero.

Ms ELLIS - I think we would have to use Freedom of Information more regularly but there is such a time delay on that. That's the difficult thing. We've got a new secretary coming and we will certainly be meeting with him at an early date to try to ensure that we have some honest sort of discussions.

But as far as ED goes, do you want to talk?

Mr BRADLEY - We support the new endeavours that the Federal Government are providing incentives to have people meet within the triage categories and in and out of the emergency department within four hours. We support that in most ways but to be able to do that we need to have proper processes within the places that we work so that the senior clinician is there to make the decisions early as to whether this patient's going to

be a discharge or whether this person's is going to come into hospital. Then the appropriate senior clinicians within the hospitals can make those decisions early to get people home. So we need to get the balance of the skill mixes right to be able to implement all these things.

We are not going to stop the increase of people presenting to emergency departments; it's always going to go up, especially with our population going up, so we have to get the balance right and certainly not cut the services that are out there to sort of try to minimise the impact of changes within emergency nursing.

These four-hour rules are a good thing in one way. They will get people in and out but that four-hour rule, when we're performing well, people are going to come to the hospital.

CHAIR - The other issue is, you can start timing at different points. I mean with the four-hour rule, that's from when they arrive in the DEM until the time they leave; that's when you have the ramping of ambulances because the time doesn't tick until they arrive.

Mr BRADLEY - They haven't arrived yet. They are still in the ambulance being cared for by paramedics.

CHAIR - Yes, so the use of these arbitrary numbers doesn't really actually improve patient outcomes or deliver better service; it just allows you to count numbers that can effectively be meaningless.

Mr BRADLEY - But if that is the only way we are going to get some funding so that I can go and do a conference or for us to buy some more equipment and get some more staff so that we can provide better things then we want to meet these targets and we want to show that we are performing. If we can't do it because of access block or various other things -

CHAIR - Shouldn't we be focusing on patient outcomes?

Mr BRADLEY - Certainly we should be focusing on patient outcomes.

Ms ELLIS - But it has been enforced on us by the national health reform; that this is the targets we have to be meeting.

Mr BRADLEY - The minister signed that.

CHAIR - I know that.

Ms ELLIS - It is going to be absolutely impossible with the bed block; absolutely impossible because we cannot get those emergency admissions through into beds because we have now closed 108 acute beds across the State. Clearly, that's going to be the area that we see as a crisis point and an emergency. And we are now seeing aged care and mental health too, staying longer and longer in our emergency department due to the closures.

Ms GORRIE - Because there are no beds.

Ms ELLIS - I also want to add to this submission that now the Budget cuts have hit CHAPS which is the Children and Parenting Support Group and we are now seeing that there is a directive that none of those nurses are replaced on sick leave or annual leave. Hence, we are now seeing young or new mum clinics being cancelled, visits being cancelled so we are actually seeing now the community missing out on some of that vital early child support.

Mr WILKINSON - The important thing about that too, and I know in Melbourne they've got a good system going -

Ms GORRIE - A very good system.

Mr WILKINSON - Where the child goes with the mum; if you've got any issues, they talk about it with the other new mums and they find out there's nothing really wrong with the baby and, in fact, it's what a number of people have had; do this and do that. That saves a medical visit and so by getting rid of that, it's a false economy.

Ms ELLIS - I know. By getting rid of our skilled nurses, what a disaster. We've got nobody there doing a manual of ongoing annual checks for someone's developmental problems such as hearing, challenging behaviour, obesity. And all those early preventable situations that we could pick up in the schools, we don't have anyone now checking our schoolchildren for hearing. When someone's not learning, they might not be hearing and yet no-one's done the testing that used to happen. Victoria and every other State has school nurses but we don't have them here.

Dr GOODWIN - Did we lose all the school nurses?

Ms ELLIS - It's been by attrition and due to budgets.

Ms GORRIE - That also supports what we raised with you about the perinatal nurses. We did that early intervention and a lot of the issues that would then come into DEM and Mental Health could be avoided.

Mr WILKINSON - We have been chasing up those people - the names that you gave us in relation to that committee - and we spoke with them towards the end of last year, so that's where we are.

Ms ELLIS - Here's another example of Federal funding with Mental Health - and you don't mind me giving an example? - I think I put it in another submission in regard to Mental Health North - $18 million of Federal funding was given to Mental Health to reduce the ED waiting time for Mental Health clients. That was going to mean another five ECAT - emergency crisis assessment team - allied health professionals with mental health skills moving in there. That was given to Mental Health North around three years ago and those positions have still not been filled. They had the money, they haven't filled the positions and now we've been told that some of that money is going to be given to the LGH to employ a psychiatric liaison nurse - finally, after three years of waiting for those positions to be filled.

CHAIR - So what's the problem there, Neroli? Is it an efficiency issue or an HR issue?

Ms ELLIS - It's HR. We've been raising at the LGH level and at Mental Health Services North ICC to say, 'These are vital positions'. We've identified them to de-escalate their vital positions. They got the Federal funding, brilliant, but they still haven't recruited to those positions. They have not even advertised for those positions. It's systems, it's HR.

CHAIR - HR obviously needs a bit of work.

Ms GORRIE - It's also true to say that with that sort of work you can hive that money off to crisis CAT so that you can say that you are marrying that functionality but in actual fact what an ECAT nurse or allied health worker does is about early intervention, keeping people out, whereas emergency crisis is usually for people who are already in the system or you're bringing people in but you don't do that intense intensive support that was the ECAT function.

Ms ELLIS - ECAT in the south has been disbanded. It was very successful and the evidence was showing how successful it was. They met the clients in the ED and followed them up within 24 hours - that was their mandate - to make sure that there was no crisis or clinical episodes et cetera. That has been disbanded and the position has been moved back into the CAT team. We have had, anecdotally, some concerns that they're not being seen now because CAT is not being replaced. They have vacancies there as well and they are having to cancel appointments across the State.

Ms GORRIE - The policy is you don't replace a CAT. It's hard to find this on a piece of paper, but I work in the teams and you place between five and eight when you're doing med runs. You don't do CAT 3 assessments, you bring someone in to do those, but if you don't have any of those down then that isn't replaced, so you work with a reduced number of staff.

Ms ELLIS - Or you cancel appointments.

Ms GORRIE - If you're in a situation where you are doing an initial assessment - you might be doing an initial assessment in someone's home - if you don't have two people to go to see the client you'd have to cancel.

Ms ELLIS - One of the other issues is around non-implementation of our new career structure, and the department has clearly stated that it's a cost saving not to implement the nurses career structure that was negotiated 18 months ago. Some of those positions now that clearly should be put into these more specialised roles are not being advertised - and I have now referred it to the Industrial Commission to be monitored and to make sure we get it implemented. It's been strategically withheld or obstructed to the implementation of a new career structure for nurses and that has impacted on these specialty appointments.

CHAIR - Going back to HR, you may not be able to comment - this may be a question for somebody else - could you comment on whether HR maybe under-resourced themselves, they are run to the bone and can't manage the work load? Or is it they're just inefficient or is it that they don't have the systems in place to facilitate the timely filling of these positions? Do you know what the problem is here?

Ms ELLIS - There are so many obstructive committees to get through. The system that's set up is set up by design to slow down recruitment. The control of HR and staffing is done centrally now through HR. The HR is working very well now it has been decentralised. We have systems and there is an HR control team and a business review team. There is a whole heap of teams and they look at every single position-to-fill form that comes through. This one team of bureaucrats review every single position. They do not agree and sign off. When the CEO has signed off on it they then have the overarching right to say, 'No, we don't believe the CEO, we don't believe the nurse unit manager and directors of nursing who have all signed off on this', because everyone has to sign this. We send it back for more information or we sit on it. It is an appalling process.

CHAIR - So do you think that with the new health reforms there is going to be, one would expect and hope, a greater accountability of the money spent where, and with activity-based funding the more you do the more money you get, and if you do things more efficiently you actually make a profit and all of that, that those decisions will need to be made or devolved from this central body that has the ultimate say, this body of bureaucrats that sits over the top here? How is it going to work?

Ms ELLIS - The Tasmanian Health Organisations, being the three regional health organisations now, will actually be accountable for their entire HR recruitment et cetera. We haven't seen the final plan of what the new ministry has in it but certainly we would not see it having a strong HR operational component at all. It may have a policy area only that would have some consistency of HR policy, but there would be no need to have any more of this bureaucratic HR processing.

CHAIR - So there could be some improvement in that, you are suggesting?

Ms ELLIS - We could see definitely an improvement in that.

CHAIR - So it would be up to the THOs?

Ms ELLIS - The THOs have their bucket of money; they know what their staffing needs are at the local level. They should be able to employ at the local level. These employees will remain employees of the State but the THO will have that accountability, and that will be the new set-up. So the HR systems should improve.

In conclusion we put some solutions down last year which really were around being a bit more strategic about this approach and stopping this crisis management and unilateral decision-making from the top, to actually communicate with all stakeholders and clinicians and to make sure we have some transparency with regard to this. The total cost for the bed closures that were in the department's documents is $21.7 million; they spent $37 million on consultants last year. We believe that is inappropriate. That is going to be really the fount of our issues and our safe patient care - the lack of acute beds in our health system. That is what we are most concerned about. There are some other suggestions that we put forward there, but certainly with the Commonwealth funding, the potential for funding, it is just imperative to make the most of that, and we are not at the moment at all.

Point 8.5 is restructuring of the DHHS and making sure that clinical and operational risk management is number one in regard to ensuring efficiency of service. We talked about

the IT, the time-sheets, the payroll, it goes on and on; every day nurses identify inefficiencies and nobody has the will to change, to actually improve. It seems so risk averse in the department to really make a difference, and workforce planning is vital.

Mr HALL - How much on consultancy?

Ms ELLIS - $37 million.

CHAIR - That's across the whole department?

Ms ELLIS - Yes.

Mr WILKINSON - It is a huge area. Obviously it is going to take time to fix. You have just been put in charge. What do you do?

Ms ELLIS - You need to be strategic. What we are not seeing now is any clear leadership and strategy, and that is what the biggest concern is. None of us has any idea where our health system will be in five years, and that is not how we should be functioning.

CHAIR - So how do we develop the strategy, though, without going to some consultants at some stage?

Ms ELLIS - We have enough reports. We have the Richardson Report. We have the Tasmanian Health Plan Report. We have Ernst & Young's mapping of the whole health system and hospitals - multi-million dollar reports. They all need to be brought together. I would get a stakeholder group of the best minds and clinicians, everybody appropriate. There are so many brilliant minds out there in the Department of Health who have been really squashed and no-one is listening to them.

Dr GOODWIN - So it is about implementation failure of all of these strategies, whatever documents that have been produced?

Ms ELLIS - I suppose it is a bit about this culture of crisis management. How long is a piece of string? If we had a piece of string as long as this room we could provide more services, but at some stage it is going to be a political strategic decision. What can we safely provide to Tasmania and what's in our best interest? That's the health plan. I think that had a lot of take in it but we have to have someone with leadership to actually implement it and make those changes that are needed, without the political interference.

CHAIR - Every decision about health has been a political decision - forever.

Ms ELLIS - Yes.

CHAIR - Where our hospitals are - it has always been politically driven.

Ms ELLIS - There need to be tripartite decisions.

Mr WILKINSON - It seems to be extremely urgent to be done. When things are going well it should be done, shouldn't it?

Ms ELLIS - Exactly; now we are starting from a back position.

Mr WILKINSON - The problem is that when we find ourselves in our position where there is not a lot of money it is probably the worst time to be starting to make decisions because you have to make decisions for the wrong reasons, as opposed to what you do when things are going well when you can properly set out a plan on how it should be done.

Mr BRADLEY - There needs to be a commonsense approach, getting the right people in the right place with all these reports. We are not a big State, not as big as any of those others on the mainland where I have worked. It could be so simple here; we don't have to travel far.

Ms ELLIS - We are missing out on so many brilliant models of care; we are not reinventing the wheel here.

CHAIR - Neroli, clearly the State budget is in a difficult position, whether we like how we got to that point or not. There have been factors outside the State's control and I believe there have been factors inside the State Government's control; we are where we are. Savings have to be made, so how do you effect the savings across Health? You can argue that Health is being cut harder than some of the other departments, and that is one aspect, but let us assume that we need to make significant savings in Health. How could they be made to achieve a similar level of savings, assuming that is the number it has to be, without cutting frontline services?

Ms ELLIS - Again, it is strategic; looking at the systems and looking at who is in the best position to provide those systems. In the IT system, sure there might be an upfront cost, but the longer term savings and efficiencies would save significant money and FTEs. The amount of things that are put in and then stopped. The clinical networks that were put in at $2 million or $3 million each two years ago have suddenly been stopped because of the budget cuts. There are so many things that are put in place and then stopped so it is a sort of reactionary management. It can be fixed. We have some of the best clinicians working in our health system with all the greatest goodwill - our health system is quite incredible. They have been battered, and I will blame some bureaucrats for obstructing some of these innovative ideas and changes, because it is very tough.

Mr WILKINSON - With obstruction, can you give me an example because it would seem that it is extremely difficult for the wheels to turn and by the time the wheels turn the event has passed anyway. Can you give an example of a problem that amplifies the matter of the bureaucracy making it extremely difficult?

Ms ELLIS - The sheets of budget cuts that came out were delivered to the CEOs the same day they were delivered to us, the same day they went to the media by the bureaucrats or the spin doctors - there are four spin doctors in the Department of Health. Those sheets are a classic example; the CEOs had not even seen them before. On the day they came out I was sitting with John Crawshaw at a mental health joint meeting with all the stakeholders around the table and he was almost apologetic that he hadn't seen it and didn't know. He was the statewide CEO for Mental Health and he has now gone back to New Zealand. That is just an appalling management style, not even consulting, not

having it signed off, not knowing that this was a strategic direction we had all signed off. To be doing that to your senior CEOs in the State is tough.

CHAIR - The Government and bureaucrats saying, 'We know what's best for you'.

Ms ELLIS - Yes, absolutely, and 'this is what you will be doing'. Some of the stuff they actually directed them to do was going to be in breach of awards and industrial agreements. So some of it was actually unlawful for them to be implementing and some of it would have serious impacts on patient and client care.

Ms GORRIE - We live in a modern society and we are a small State. If you have an electronic data system that is sensible and functionable, just think about the cross-information between GPs, hospitals, community and child health. Why aren't we doing it?

Ms ELLIS - We do have to make that hard decision about what service is going to be delivered where. At the moment we're still trying to deliver everything everywhere to everybody at any time they want it. John, you mentioned on the way down here that the public is still choosing when or not they are going to be transferred up north. Those sorts of decisions have to stop. It's the clinicians who must say when it is safe for you to be transferred to another unit, not when it suits you because of your personal situation.

Dr GOODWIN - I want to touch on the infection control issue. Could you perhaps elaborate on that?

Ms ELLIS - This is around delaying elective surgery. There are also infection control issues and research showing that when you start changing the configuration of wards - say, by amalgamating orthopaedic and surgical wards - you may have a 'dirty' wound in with someone who is an orthopaedic patient who has had a clean prosthesis put in that cannot risk having any cross-infection. What we're seeing now is they're proposing to amalgamate - Surgcentral north west has orthopaedics, surgery, clean and dirty all in the same rooms. Research is very clear, it's evidence based, that that is not appropriate. Infection control research has shown that there are problems with that.

Dr GOODWIN - So that's a separate issue to delaying elective surgery, which also has an increased risk of infection?

Ms ELLIS - This is the delayed surgery for acute severe (*inaudible)* and associated increased risk of post-operative complications produced during general surgery. That is the research that shows that delays led not only to the increase in cost but that's it twice more likely to have infection post-op, and that is because of a decrease in movement before, a decrease of a lifestyle and an increasing reliance on medications pre op. All those sorts of things make you more of an operative risk.

Ms GORRIE - The more complex they become because they become depressed and put on weight and then you have diabetes.

Ms DRIVER - There are renal issues, which means you can't use certain painkillers. Once you start getting renal problems with diabetes you're in trouble.

Dr GOODWIN - It's all pretty grim, isn't it?

Ms DRIVER - Again, education in the community about their own health - increased diabetes, increased obesity. That's a lot of money, isn't it.

CHAIR - If you look at the health plan, that's what we are focusing on, isn't it?

Mr WILKINSON - Are we getting to a situation where we have too many hospitals and too many hospitals endeavouring to deliver services to everybody, as opposed to people specialising in certain hospitals? I think we're always going to have this type of problem while we have too many hospitals for our population, too many hospitals trying to do too many things.

Ms ELLIS - I think the issue here is that we may not have too many hospitals, we have too many hospitals trying to do the same thing. There is a safe number of throughput for surgery, which is *x* amount per year, to maintain the surgeons. In the health plan it was very clear that Mersey should probably be doing day surgeries and other types of procedures - I think it was oncology - whereas North West should be doing the higher ICU-type, more complex work. Again, that was very political to be changing. The community is obviously very passionate about the Mersey. My personal belief is that is not too many hospitals but too many hospitals trying to do the same thing. Quite often that is medically driven, about where they're based and where they want their services.

Mr HALL - Just a general question, Neroli, and I don't expect you to comment on personalities, a new secretary of Health has just started?

Ms ELLIS - On Monday.

Mr HALL - Given that people ask us as MPs in our local areas, and apart from Ruth who has been a health professional, it's very difficult for us to get our heads around it. Outside the political dimensions, should it be that the secretary of the Department of Health is the one who cuts to the chase with a lot of these problems and tries to sort all this out? It has to be somebody very strong and proactive.

Ms ELLIS - We have had Greg Johannes doing that role and it was a breath of fresh air. He cut to the quick and was very honest and dealt with issues that we have had standing there for a long, long time. It was wonderful to see someone who was prepared to shake up the department. John Crawshaw did the same when he was acting

Ms GORRIE - He was really good and then he just left. He even said, he made a very interesting statement that day when he said, 'What I say to you now will probably be very different to what is actually announced after it goes through three or four people who modify what I am about to say'. That was a classic example of bureaucracy and he said that.

Ms ELLIS - But nothing can come out of the department by anyone in the department until it has gone through the spin doctors to be sanitised. We hear frustration from all of them.

Ms GORRIE - Also in the consultative committees, it is called 'consultation', but when we raise the issue of definition of consultation because normally consultation is seen you

listen to what I say, listen to what you say and then we meet in the middle. I was berated by saying more senior and higher management people will be making the decisions, basically saying that we were saying would not even be taken into account. Because usually by the time that it comes to us the decision has already been made. But we can go in and look at the industrial issues and the risk assessments and we create the paper trail that hopefully someone can look at one day and say that this is where we went wrong. But some of the best ideas, like we keep pushing the IT, we keep pushing the credentialing and I do not understand. I think mental health in Tasmania could almost be funding itself from Federal sources if we did it properly. That is what I see as the future direction and needs. It should be very much primary and community based.

Dr GOODWIN - So the frustration is that it seems to be top-down driven and there is not enough of real consultation.

Ms ELLIS - Real consultation. The consultation on the decision that has been made. The people who are making the decisions are not clinicians so they are making decisions based potentially on budgets. And then there is reaction and there are disputes and sometimes wrong strategies are implemented because of that.

CHAIR - The issue of IT is not just with mental health.

Ms GORRIE - No, we all raised it.

CHAIR - It is right across the board. It is payroll, it is HR

Ms ELLIS - And it is clinical systems.

CHAIR - It is clinical patient data. We still hear from GPs that they are not getting discharge letters for six to eight weeks which is a complete nonsense.

Ms ELLIS - They do not even know that the patient has gone into hospital.

CHAIR - Let alone gone home again and needing follow up. It is a huge issue.

Ms ELLIS - The National Health Reform, which we would have separate funding again for the community versus the hospital system, is going to be potentially open for cost shifting as well and early discharge.

CHAIR - That problem does not go away until we have one funder.

Ms ELLIS - Exactly.

Mr BRADLEY - Especially with the electronic health record that is supposed to be coming through as well.

CHAIR - Hasn't it been put on hold though?

Mr BRADLEY - I think so, there is a real chance that it would improve communication.

Ms ELLIS - We think there is potential in the Department of Health but there are so many issues in the structures, the efficiencies, the strategic direction that we do believe that there is a lot of room for improvement. We are looking forward to meeting the new secretary and hopefully working through that.

Mr HALL - Educate him quickly.

CHAIR - Neroli, thank you. We are out of time but is there any other closing comments that you would like to make or anything that you have not said that you would like to make.

Ms ELLIS - I do think that we are about to see the worst to come. It certainly will be worse going forward because we have had a Christmas slow down, surgery has been on hold for the month of January, we will now see the real impact hit from now on when surgery starts again this week and bed capacity is going to be the crux of it. Without the 108 beds we are going to see some problems in our system right across the State.

Ms DRIVER - I think the best view would be if you could be a fly on the wall on an evening shift in a surgical ward or somewhere like that and see the chaos that is going on. People are still working as hard as they can.

CHAIR - Maybe the committee should visit the surgical wards of each of the hospitals of an evening to see what happens. Thank you for coming along and thank you for your suggestions..

Ms ELLIS - Thank you.

THE WITNESSES WITHDREW.

Mr STEPHEN COOMBE, REVENUE PROTECTION SERVICES, WAS CALLED, MADE THE STATUTORY DECLARATION AND WAS EXAMINED.

CHAIR (Ms Forrest) - Thank you for joining us. What you say is protected by parliamentary privilege while you are here. It is all recorded on *Hansard* for the purpose of preparing a report. It is a publicly available document on our website. If you say anything outside of the hearing you need to remember that it will not be covered by parliamentary privilege.

We have your submission and our previous witnesses were talking about IT challenges and data management and that sort of thing.

Mr COOMBE - I have an investigative background and since the early 1980s I have been involved in analysing lots of data as an investigative process and also for business improvement. I started off in the early days of Medicare, back in the early 1980s, and I built on that work in different organisations. IT has moved a long way. In the older days it was a manual IT process; now we are moving to the stage where everything is a lot more automated. People have a terabyte of hard drive on their desk at home where as before that was just in the realms of an organisation.

I continued with this interest, and I work with different organisations. When I joined the then Hydro in 1996 I was fortunate enough to go to the UK and speak at a revenue protection conference. The old-fashioned view of revenue protection was that you are protecting money that perhaps you have already lost. That has evolved over time to revenue assurance, which is actually trying to prevent the money from going missing in the first place, and improve efficiency. The next step is business assurance, and that is providing a near real-time audit functionality.

I was invited again to present at the same conference in 2009. I was approached by a lady from a big electricity network company in the UK and she was thinking much along the same lines as I about the use of data. This is electricity revenue protection assurance but the same methodology applies in any large organisation, so forgive me if I keep talking about electricity but that is where it started. While I was there I also met with a colleague of mine who works for WeDo Technologies, which is a Portuguese company which has a 25 per cent share of the revenue assurance market in the telecommunications area. Here we are analysing massive amounts of data. They have a solution in Russia that analyses four billion transactions a day, so dare I say that the Tasmanian Health department would pale into insignificance in the amount of data. It may sound a lot but the technology has progressed so far that it is not difficult.

I mention in the submission that from the UK I sent an e-mail to the then Premier, David Bartlett, and Peter Davis. The lady in the UK is looking at having a national revenue protection service for the whole of UK - 22 million customers. I am working with WeDo Technologies, providing a response to a tender to provide that service to the UK.

When I came back to Tassie I had a meeting with Mike, who was the then Premier's IT specialist and he could see the value of it. We talked about Intelligent Island and the National Broadband Network; it just makes the shuffling around of data so much easier. I guess we then hit the reality of, dare I say, working with some government departments because it all sounds perhaps too difficult, perhaps we don't want to upset the applecart,

perhaps we're going along a particular line. But he suggested that I could talk to TMG, the telecommunications group, which I have. I have also been talking to Aurora for about a year, and then we come to the presentation that you speak about, which I gave to Penny Egan, the CFO, in May of last year. She seemed quite interested in the concept and one particular item, bearing in mind this software comes from a telco background, and it is the communication cost-control module. We spoke about an issue where I think the Health department suffered a loss where someone who was in care of children, $150 000 or what have you, and that happens because they probably only bill monthly, whereas the philosophy of this solution is that you incrementally get the data every couple of days so as soon as there is an issue you can do something about it.

That one is relatively simple in the context of a telecommunications issue. But they are moving from a revenue assurance solution to more of a business assurance solution, and that is mapping the whole of an organisation. I guess it becomes more of an imperative with the national health reforms that are coming in that the bill you get from a doctor for work that is done on behalf of the Health department, he actually did. That can be done manually but if there is cost-cutting within an organisation there will be fewer people to do the checks and balances.

What surprised me a little was that they went from being relatively interested in the concept to, 'This group's looking at it, we'll get back to you' - and then nothing.

CHAIR - I was particularly interested when I read that you said PricewaterhouseCoopers had estimated leakage in the health care industry at between 5 per cent to 10 per cent in the budget, which is between $80 million and $160 million per annum. Obviously that is money we cannot afford to see disappearing.

Mr COOMBE - Absolutely, that's right.

CHAIR - What sorts of costs are we looking at in implementing a system that would prevent that and put this money back into the system, so to speak?

Mr COOMBE - It is about how we would price it in this because it is normally based on the number of subscribers for a telecommunication company or the number of meters in electricity contracts. But we do technologies that are very keen to move from their area of expertise and utilise it elsewhere. I am led to believe their pencil is very sharp. But the module, just to look at the phone side of things, you are talking about $20 000, $30 000 or $40 000 perhaps. For the whole box and dice, $500 000 to $1 million. You spend $1 million to save $160 000 million. The beauty of it is that it is not just used for that; it is limited only by your imagination, really.

CHAIR - Things like chasing up private patients using public hospitals and not being billed - those sorts of things, those other revenue streams?

Mr COOMBE - Yes, absolutely, because it has the ability to pick up data in any format. As you say, you would have one system that would have that billing information and then you'd actually have hospital data on patients coming in - Joe Blow was here on such and such a date for so many days. That's when the private health company should be billed. What this has the ability to do is to present a very high-level view. If I can just use the electricity example again, I think you could probably apply the same logic coming

through. Hypothetically, what should happen is whatever amount of energy Aurora purchases from the national market, the meter readings they get when they come around to read your meter and what they bill, should all add up. But no-one ever does that because it's too big a task.

CHAIR - Manually?

Mr COOMBE - Yes, but they don't even do it -

CHAIR - No cross-referencing or checking.

Mr COOMBE - No, because in the utilities area you're looking at between 1 per cent and 5 per cent of losses. In the old days, with the group that I set up at the Hydro, at the end we were saving about $5 million a year for a group that only cost $300 000 or $400 000 to run. We were using Microsoft Access spreadsheets and the like. But when you go to the next stage the data is automatically received daily so the data is collected, sanitised to make sure it is correct and added into the mix. So at a very high level it will tell you that you are purchasing 100 per cent but you're only billing 85 per cent, and then you can drill down to whether it's predominantly in a particular region or sector.

CHAIR - So even consumables - for example, how many bandages or sterile cotton swabs -

Mr COOMBE - Yes.

CHAIR - that a hospital purchases, or the health system in Tasmania. Even just tracking the ordering, the receiving and the distribution; do you think there are losses in those areas as well at the moment; that we don't actually receive things we order and pay for?

Mr COOMBE - I guess there could be losses in two areas. One is perhaps you're not getting the stuff you've paid for and then once you've got it, I dare say some of it may be not being used for the purposes it was purchased for.

Dr GOODWIN - Or you could be ordering too much of something you don't need.

Mr COOMBE - Absolutely, that's right. A favourite expression of mine is 'sunlight is the best disinfectant', and this is basically what this is. I've developed systems on a much smaller basis in Medicare, in the Hydro and the Trust Bank and, just by analysing the data, it's very easy to pick out. It hasn't failed yet and this is a much bigger and much more worthwhile opportunity.

Dr GOODWIN - For it to work in the first place, you need to have some sort of electronic data systems in place.

Mr COOMBE - Yes.

Dr GOODWIN - That may well be the problem. We've just heard from the ANF that there are some significant IT issues within Health and I wonder whether that is a factor.

Mr COOMBE - Yes.

CHAIR - But you would think that wouldn't be the case in their billing.

Mr COOMBE - No.

CHAIR - Certainly with their patient data I'd say there is definitely an issue, but for their billing, receiving and dealing with stock and things like that, surely that would have to be at the top. We're not still writing on one side of the ledger and ignoring the other, are we?

Dr GOODWIN - I don't know.

CHAIR - We spoke to Penny Egan about it and she said your submission suggested she was quite interested in it, and then nothing happened. Have you got any idea about where it went from there? For instance, is it worth us talking to Penny Egan again about what barriers there were to introducing this?

Mr COOMBE - Perhaps, yes. Having spoken to her, I don't know if it was before or after - I'll have to check - but I actually sent a letter to the Minister for Health. That was before 4 February.

CHAIR - Last year?

Mr COOMBE - Yes. I didn't get a reply at all to that. I then spoke to Penny off my own bat. I also sent an e-mail to Greg Johannes but didn't get a reply. I know this stuff works and I'm pretty passionate about it. I take your point that perhaps the IT systems aren't very good but even if you started in a small way and said, 'Let's just look at the telecommunication costs', for example. They had that $150 000 error. I don't know how many phones there are in the Health department - we'd be probably talking thousands I would say - but there may well be some that aren't being used but are being paid for. Systems such as this can quickly pick that up.

CHAIR - The figures that PricewaterhouseCoopers talked about, leakages in the health industry, was that specifically looking at Tasmania?

Mr COOMBE - No, that's a worldwide view.

CHAIR - Is that then applicable to Tasmania? I know health services are health services but PricewaterhouseCoopers is saying 5-10 per cent leakages and if you quote the 5-10 per cent in the DHHS budget that comes up with a figure of between $80 million and $160 million. I'm a bit cautious in suggesting that that would be the reality. If it was only focused in certain areas such as telecommunications or billing of private patients and those sorts of things, obviously it's going to be less. Do you have any idea of the quantum of savings - although they're not really savings, are they, just recouping money that would otherwise have been lost?

Mr COOMBE - That's right. Even if you only get 1 per cent, forget the 5-10 per cent.

CHAIR - But for the investment, though - if it's a smaller investment it is a smaller scale, obviously.

Mr COOMBE - Yes, that's what you do. You start off on the small scale to get the concept working. I have worked in some different Tasmanian organisations and, for example, we were routinely recovering $4 million, $5 million, $6 million at Hydro/Aurora in accounts that weren't billed. Perhaps the Health department is better, but perhaps not.

CHAIR - Do you see any other applications within the department or across government perhaps? We're focusing on Health and the savings strategies. We're cutting into frontline services and that sort of thing. Obviously the reason that's happening is because the Budget is in a difficult position at the moment and there are cuts right across.

Mr COOMBE - For any organisation that has the data - you need to match. You have your audit departments which tend to audit annually and take a sample. What you're doing here is auditing continuously, picking up the problems. It has taken me 12 months to get through to Aurora. I used to work for Peter Davis - he was my general manager and then became the CEO. As we know, there have been big changes at Aurora in both personnel and structure. When I first approached him about this back in February of last year they were just putting in the new billing system. I guarantee you that there are issues with that because when you transfer data from one system to another you'll get errors. I know myself, as a personal consumer, they sent me a bill for zero dollars because there were errors with the data, so I brought that to Peter's attention. I think they're slowly warming to the idea that they need revenue assurance.

CHAIR - Well, their billing system is a bit of a disaster. It has cost them much, much more than was expected.

Mr COOMBE - I think the nine or whatever it was, 19 before, was an impossible figure, but 60 is even more. I used to manage the billing system for Aurora so I have some knowledge of that but no, there is a whole raft. If the IT systems are there, even from a child protection perspective, if you have *x* number of children that you are looking after and when a visit is made it is recorded electronically, you could record that. You could say, 'Little Johnny hasn't been seen for' however long and provided you have the data protection issues looked at you could match it with data in the police system. The possibilities are endless really.

Dr GOODWIN - Could it help also with HR issues like overtime rorting, sick leave rorting and all of that sort of stuff?

Mr COOMBE - Yes.

If we look at the electricity perspective, you get errors and omissions which are exactly that, and you would get them in what you have just spoken about, and then you cross that line to fraud and deliberate actions. The level that you analyse is up to you. You could perhaps link it to build-in access data, 'Someone hasn't gone into the Royal Hobart, how can they claim to be working 9 to 5'? That is a little bit Big Brother, but is it that bad really? You shouldn't be claiming two hours' overtime if you weren't there.

CHAIR - That is a very paper-based system at the moment because they still fill out paper time sheets.

Mr COOMBE - Yes, I hear this a lot. That is right, yes.

CHAIR - And there is no link and they do a second pay run every pay period to make all the adjustments for people who didn't work what they said their roster was going to be, either because they had shifts cancelled or they had to work extra, which is more likely the case, so the adjustments cost a huge amount of money. It is interesting that there is an opportunity here to reduce loss which subsequently puts money back into the system.

Mr COOMBE - Well, it does, because what I tend to find is that when you implement systems like this and people realise it is working, whereas before they might order 1 000 widgets a month, they realise they only really need however many, so eventually you do actually -

CHAIR - Make cost savings eventually, yes.

Dr GOODWIN - And it is just a one-off investment, is it, in a system?

Mr COOMBE - That is right. With any IT system there is licensing and ongoing maintenance and what have you.

CHAIR - They are not huge costs.

Mr COOMBE - No. And it is not a big bang thing. I have come to talk to the Health department; I have the guys willing to come from Portugal - they have an office in Singapore - to sit down and talk. You might then say, 'Well, no, it's really not for us', or, 'We didn't even get to that stage'. I see this sometimes, 'We have been doing it this way for 20 years and we don't want it to be highlighted that perhaps' -

Dr GOODWIN - They might be frightened about what you would find.

CHAIR - Exactly.

Mr COOMBE - I know. The area that I work in is a bit like that. You only need a plumber because there is water gushing out of the bottom of the sink, but you don't know that you are losing money or you are paying too much or you are being defrauded.

Mr WILKINSON - Or your feet are getting wet.

Laughter.

CHAIR - Or your shoes are wearing out more quickly so you end up paying more for shoes. It is like a preventive medicine type of thing, isn't it?

Mr COOMBE - That's right.

CHAIR - Jim would remember when we had the Public Accounts Committee presentation by Child Protection Services. They have a huge amount of data that is collected electronically now so there are some sectors of the department that seem to be well placed to implement a range of options potentially but there are others like the payroll and patient data management that would be a fair way behind. There are others, apart

from the billing. You are billing patients that you can bill like the DVAs, the MAIBs and private patients.

Mr COOMBE - I had the misfortune recently to suffer a very bad nose bleed after a minor nose operation and I had to go into the LGH. I thought I would wait and see how long it took me to get a bill and I have not seen anything yet. Hopefully, it has been paid for by Medibank Private but who knows?

CHAIR - Did you tell them you were a private patient?

Mr COOMBE - Yes.

CHAIR - Maybe it has been paid direct by Medibank Private.

Mr COOMBE - Yes.

CHAIR - Sometimes they will bill them directly.

Mr COOMBE - They are the kind of things you can do. You can talk with Medibank Private about the fact that you have actually issued an account to them so you can drill down to an individual John Smith, 'Haven't done it' but roll it up to a much higher level to say, 'Of the 200 000 patients we have seen this year *x* number were private patients but we have only billed 80 per cent of them. Why haven't we billed the other 20?'

CHAIR - In the list of the saving strategies that have affected the department some of the agency-wide ones which are more applicable to what you are talking about are telecommunications, mobile phones and data cards. Obviously they are trying to save money there and if you wanted to redesign payroll administration and processing and lease facilities there may be a facility fee - it doesn't appear to be here. There was a mention at some stage by the minister, I think, about them chasing up private patients and that sort of thing or the private health funds. That might have been in the budget Estimates and you might have mentioned that across the table. When you look at these agency-wide saving strategies you wonder how they are going to achieve them and maybe this is a way that it could be looked at.

Mr COOMBE - That is right, and you can start off small. I don't know how much the Health department spends on telephones for the year but it would have to be in the hundreds of thousands of dollars and even if you just designed it you could have a proof of concept just to show that working and then you say, 'That is okay; I like the look of that' and then we could add other stuff in too.

CHAIR - If they can achieve the reduction in overtime of 5 per cent that will achieve a $1.3 million saving each year, I assume that is what it is, but it is interesting to know how they are going to measure that. They don't have a really good record of how much overtime has been worked and how much is being worked. There is a wide range of applications there potentially.

Mr COOMBE - Absolutely.

Dr GOODWIN - Are you aware of any other Health departments around Australia who are doing this sort of thing?

Mr COOMBE - This is a relatively new concept because, as I said, the IT just moves so fast. With the move from revenue protection to business assurance there are some disciples and we do technology as one of those. If you can imagine the whole of a large Russian telecommunications company and the complexity of that, if you look at electricity billing you have two meters read once a quarter and they issue a bill but with a mobile phone you can travel around the world with different carriers, you can download and use data and to manage all that data is a huge task. So they built this system to do that and now they are seeing the applicability of using that for other processes. So that is why they have gone from revenue assurance to business assurance. You just provide the data; it does the matching. It has case management systems, so if Stephen Coombe comes into the LGH, he is a private patient but after *x* amount of time we would have him in Medibank Private, so flag it up. That is then all rolled up to a high level so that you can say, 'Hey we have a big issue here', but then also down to the individual level.

CHAIR - This sort of company provides a fairly well supported service level agreement? They have obviously developed the software. If it is going to be used in Russia in the way that you described then they must be fairly confident in its reliability.

Mr COOMBE - Absolutely. It is in 60 countries around the world. Vodafone use it. I have been speaking to Telstra. They have their particular brand that they are using.

Mr WILKINSON - Would the way forward be, rather than this committee say that the Health Department should be doing this or should not be doing that, to say to DHHS that maybe you speak with such and such and you can view how the process works and then decide whether it is an appropriate method for them or not?

Mr COOMBE - That is exactly right.

CHAIR - It would be interesting to know why, when there is a sudden death, when there appeared to be a level of interest. Is it really because of budget constraints or are there other concerns.

Dr GOODWIN - And broader applications across other agencies at a time when everyone is trying to find savings.

Mr COOMBE - That is right. That is why I made the submission. I am thinking there is lot of money to be saved and then you get the poor people who are missing out on their surgery and what have you - the human element - and we have got to cut $100 million out. Here is an idea that I know works, so have a look. We went so far and it just sort of went into the ether. That is the reason that I put the submission in.

CHAIR - It was a left-field submission in that regard but it was interesting to read it and to talk to you about the potential applicability, not just from a heath perspective but for whole of government. Certainly the approach that you have made to health is interesting.

Mr COOMBE - And it is not just applicable to health. I know we use the term glibly of an intelligent island but there is an opportunity here to say we have gone to the nth degree; this is the latest technology and look at the results we are having. I have resurrected interest with Aurora where it is directly applicable, and also TMD. The Health department would be good.

Dr GOODWIN - This is slightly off the topic, but with Aurora there are certain individuals in the community who have extraordinarily high electricity bills because the are using the wrong heating. I am thinking of a constituent of mine who every winter has a huge spike in her power bill. That sort of system would presumably show up some of those individuals and then maybe there is an opportunity to help them reduce their power bills.

Mr COOMBE - Absolutely. In my particular case I got this bill for nothing; it just said you do not have to pay anything. I sent an e-mail to Wendy Harris, who used to work for me when I worked there. I explained the situation and she checked the data and my $750 bill went to $345 and then I got a refund. Was that as a result of the new billing system?

CHAIR - I'm not sure whether it was but it was around that time so it probably was. My constituent argued the point that they knew they owed money but Aurora said they did not.

Mr COOMBE - We talk about pay as you go; it's sold as a product of choice but there can be awful issues because of when people are using it. Part of this software is margin management. You are trying to say, 'If we sell electricity at this price at this time we'll make *x*', but unless you fully know what is happening you could be not charging enough or charging too much. I reckon there would be some issues there too with data integrity for pay as you go.

CHAIR - Thank you for coming along and supplying that information.

THE WITNESS WITHDREW.