Australian Nursing Federation
(Tasmanian Branch)

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

Appendix B
ANF Member Comments Regarding the Parliamentary Inquiry

December 2011

ANF Member Comments
Parliamentary Inquiry

A major risk for the LGH DPU if they get rid of the proposed 14 contract workers is who will cover meal breaks and sick leave. I am on a contract and trained in all areas including endoscopy and recovery. I often come to work, work on the ward, then move through the unit covering meal breaks. Or if it is busy in an area I work there. If pool/permanent workers take our jobs or if they just go this ability will go. We will work short staffed with no breaks.

Continuing Waste / Inefficiency

Patients making multiple trips to Medical Imaging for investigations because of a non integrated booking system and poor planning.

Many examples of patients going for an ultrasound in the morning and having to return for x-ray / CT in the afternoon, or vice versa. Wastes clinical and patient time.

Same for OT, many patients make trips to OT, (especially those with complex care issues / multi trauma.

Many examples of patients going to OT for an e.g. ENT procedure / dental etc, and then having to return later same day or day after for Ortho / Gen Surg work etc. Could be helped if hospital had more staff specialists. Very hard to get consultants to leave private work or sessional work to facilitate co-ordinated procedures.

Obviously involves doubling,(sometimes trebling), up on transport to OT, checklists, recovery, theatre time, orderlies, admin, as well as exposing patients to multiple anaesthetic risks.

Many issues similar to this exist within other departments.

They are savings to be had in the goods and services area. We dispose of scissors and artery forceps and dressing materials which once were recycled. Also patients used one towel and face washer which was kept by the bed to dry and reuse per admission and only changed when dirty. Bed linen was only changed when dirty or the top sheet was used for the bottom sheet. Also Kylie's or pinkies used in the past stop a lot of extra linen being used. Now the whole bed has to be changed not just the Kylie. Also patients were told to bring in tissues, cordials etc that they wanted. Now the ward provides these. The discharge lounge for patients is successful in other hospitals so why not here? Poor planning means patients are still in the ward at 1300 hrs waiting for scripts or transport which means that bed could be used for someone else. This is the only state that I know of that the ambulance is free. All Tasmanians should pay an ambulance levee or pay for the service if it is used. The Acute Medical Unit should be opened when the beds at the LGH closed so services can still be provided. Also the government should look at a fee for service. It would mean that patients have the opportunity to purchase services if they can. Obviously patients with a health card would not be included. Dee Douglas

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Re: Older Persons Mental Health Services, South.

Tasmanian demographic data illustrates that this State has the oldest population of Australian states and territories.

- Elderly people suffer disproportionately from mental illness, self neglect and suicide.
- I would estimate that around 65% of our new referrals are at risk due to dementia.
- It is predicted that rates of dementia in Australia will double from the present level within the next twelve years.

- We are aware that our small team of community mental health workers, servicing the entire Southern Region, is already vastly under resourced compared to other parts of Australia (e.g. Perth W.A.).
- We are already struggling to cope with our rapidly increasing rate of referrals and workload.
- We are expected to provide comprehensive care under an assertive case management model, but it is currently impossible to do this well with our already meager resources.
- We need to have our resources substantially increased now, not decreased, to have a chance of providing a quality service to our deserving older people into the future.
- We believe that our work is of great value to our community, but team morale is being particularly affected by this quite sudden and poorly planned rush to make sweeping cuts to health services generally.

Highly trained nurse working (ACAT assessor, Aged Care Cert) on temporary contract in LGH moved back to substantive position on ward 3R by blanket rule of returning staff to original positions.

Waste of expertise and training under taken in the past 2 years for role in HALT Team (Hospital aged care liaison team) keeping elderly out of hospital and supported in their home.

Not cost effective. Loss of investment.

Theatre - nursing staff have been trained to this highly specialised area leaving for stable positions on mainland. Loss of investment.

Humanitarian aid nurses unable to participate in volunteer work with recognised aid agencies abroad without access to leave without pay until all accrued leave is taken first.

I understand we need to have health cuts my question is who is looking at the way services are managed and how productive they are being managed. I have heard a lot of comments about front line services being cut but what about the number of team leaders and managers that exist across all services. I assume managers won't be looking at their own jobs or will they?

After discussion with nursing staff in NPICU RHH we ask that you forward our concerns to the parliamentary inquiry over the potential loss of those members of the nursing staff who are coming towards the end of, or have not had their contracts renewed.

Our concerns are that there is no job security and we may lose these valuable nurses at a time when many of our permanent staff are approaching retirement age. We struggled through the NHPPD grievance to gain extra staff and were encouraged to train our own NPICU nurses. This has been successful and we recruited graduate nurses who were looking forward to completing their postgraduate studies next year, only to be left in this limbo situation.

Staffing in NPICU cannot be propped up by, 'a pair of hands', they have to be skilled hands. We do not want to go down the path of further grievances which will no doubt occur if our skill mix deteriorates and we're back to working overtime and double shifts. This is not cost effective, not safe for patients and OH&S standards.

I am a RN at RHH in the outpatient clinic, working in the Wound clinic, Dermatology and Plastics Clinics.

I have been made aware this week that there are a number of outpatient clinics under threat as a result of a proposed cut to reduce Plastics medical staff by 1.3. The impact this would have on the clinics is believed to be as follows:

1. Closure of the outpatient wound clinic (believed to safe the RHH hundreds of thousands of dollars each year by managing chronic wounds in the community further reducing hospital admissions and surgery associated with them)
2. Closure of the Holman head and neck clinics - Used for treatment post SCC removal for radiation therapy
3. The burns outpatient clinics (I am unsure of all of this affect but believe children with burns would then have to fly to Melbourne for treatment)
4. Loss of accreditation as a teaching hospital in the division of Plastic Surgery

I am led to believe that the decision to go ahead with this is under collaboration as we speak and the outcome should be known soon. I ask that you investigate this and bring forward an argument against the proposed cut. I believe all doctors and nurses also oppose these cuts.

I have also heard this week the Dermatology Registrar position is again under threat for the second time in 12 months. There is only one Dermatology consultant and one Registrar to serve Southern Tasmania at the RHH and the loss of the Reg who sees 80% of the patients who have enormous effect on the early detection and treatment of skin cancers.

I simply cannot understand the rationale behind the above mentioned proposed cuts to the RHH. I am not at this stage concerned about my own job but of the people who would miss out on medical treatment as a result.

Re cuts/DoP: National mental health strategy-not supported by Agency. Where has Federal funding gone? Cuts to frontline staff- beds to be closed? December (likely masked as rebuilding/revamping; watch for further bed closures).

2014-PICU to go) Cut to management team nominal only. Whole question of Risk: less beds, more pressure on DEM; pressure on denuded (PEN position gone/federally funded/Catt teams to be reconfigured) CMH services and police; likely poor outcomes for clients-where to be treated/likely increase in length of hospital stays/prolonged illness exposure. Workforce/ pt's exposed to risk of violence .See next for risk related to retention issues.Workforce: extant RETENTION problems on Dop denied by agency; extant poor skills set (add to risk) likely to further erode; threat of cuts creating fear in junior staff/likely will go to mainland. SOLUTIONS: Royal Commission into funding arrangements and their disbursement. DHHS has entrenched nepotistic fiscal and staffing arrangements

Please regard just transmitted email as without prejudice. Can I add that many staff are fearful of reprisals from DoP management?

These are my thoughts on the impact expected with our budget cuts

And the current environment which has been effected for quite a few years now by budget cuts.

Child Health and Parenting Service:

We are not sure of our new model of care; it is to be disclosed to us on 22.12.11.

Assoc. Prof. Des Graham stated CHAPS should be directed to vulnerable families & that middle class families should pay for this service.

We say many / most new parents are vulnerable at some stage in their parenting role & a universal service allows them to be supported at that time, as well as normalising the service for all parents & not labelling some parents as less capable.

We do family assessments & mental health assessments, which are early intervention opportunities, to allow for the best outcomes for babies & their parents/families.

It is the middle class mothers who generally breast feed for longer, & it can be the support from CHAPS nurses that get the mother's over difficulties to allow them to continue breast feeding for longer, which contributes to a reduction in many future health issues.

We have experienced staff shortages for a long time now & have already reduced our Hey Mum's Groups from 6 to 4 weeks & some areas are not able to run groups at all because of staffing shortages. There is a demand for these groups & the women who miss out are disappointed. The groups create powerful community networks for families that last for many years.

Because of staffing shortages we cover each other for annual leave or other leave resulting in reduced services all round. The wetaway nurses who help children with enuresis & the CU@home nurses have been redirected to cover centres for all types of leave many times in the last couple of years.

Our current model of care is focused by funding for nurse health assessments in centres. This has reduced our ability to work with vulnerable families in their homes, due to time & transport constraints. We believe this will be changed with the model of care review.

We know that the early years are vital for a child's healthy future & the current investment via CHAPS, as well as other services is necessary to support families & children towards this healthy future for our community.

It is obvious that the decisions are made by untrained people who are only interested in justifying why THEY have a job. The over monitoring of the aged sector and duplication in all health areas is unacceptable. This leads to waste of our resources and puts more strain on the people actually doing the work.

The agenda is actually removing health care and reduce our population and this is documented by us now having a "SUSTAINED POPULATION MINISTER' which does not mean sustaining our present population but reduce our population in Australia to 9M people. I wonder what they are going to do with the other 15 Million.

Our health planning tells the story.....we have to stand up for what is right and really know who the enemy is.

These health cuts are not going to save money – not in the short term and certainly not in the long term.

The cuts are short sighted and do not look at the impact on the aging community, staff and the relative isolation from the mainland.

People are going to die.

The risks of not meeting the National Health Reform agenda are:

Loss of income from not meeting the Activity based funding (ABF):

- By the reduction in actual beds throughout the State. How can you increase activity if you reduce the ability to "house" the patient while the elective surgery is performed?
- Emergency patients will use the limited beds available leaving little to none for elective patients
- By not meeting planning, funding and delivery of teaching, training and research it will effect training of nurses and doctors into the future
- We will not meet the funding for predicted growth in the Public Health system
- Improvement to patient access to services and health outcomes will not be met
- The state will not be able to meet its agreement under the reform to "provide health and emergency services through the public health system" NHR document 2011)). Access is to be based on clinical need.
- Patients will be discriminated against as the Public health system will only be able to take emergencies not planned elective admissions
- In desperation there will be patients deemed as an emergency to get health care – surgery when in a normal functioning system a priority system would prevail putting more strain on the hospitals

Continuing waste and efficiency:

- The vacancy control mechanisms currently being practised is inefficient, does not allow any flexibility and is creating more waste by increasing double shifts to cope with current patients.

- The dragging out of recruitment and filling of permanent positions although may seem like a cost saving the cost is not as they are deflected elsewhere into loss of potential staff to the mainland, increased risk to the staff and patients on the ward, and emotional angst for those in fixed term positions
- Managing the Establishment numbers is inefficient. Funding to an establishment number rather than to a personal employee number:
    - Rigidly puts the funding against the establishment number
    - Reduces flexibility to adhere to the family/life style/work balance policy
    - Promotes manipulation of the establishment and allows scenarios where more than one person (body) is in one position and subsequently leads to unfunded positions
    - Encourages multiple fixed term positions thereby causing industrial permanency
    - Inaccuracies in the Establishment numbers
- Double shifts, extra shifts called in from days off to look after the patients already in hospital is not efficient or saving money
- Why not fill all permanent vacancies in the agency – a predicted and supposedly known cost in the budget and then look at what is left over before sacking fixed term employees?
- Start working now on how to fix the recurrent problem of being over establishment and having more than one person in a position.
- Let clinicians work out what their workforce needs are and align that with the establishment and the dollars.

Workplace planning, retention and skills sets:

- A large number of 2011 graduating nurses in Tasmania will not be recruited into Tasmanian hospitals for the transition to practice programs in 2012
- Nurses about to finish the Transition to Practice Programs will not have employment in Tasmania in 2012
- All the investment in education, training and mentoring these nurses are wasted to this state.
- If there is not the job opportunities then why would you, when looking for a career, choose to enrol in the University of Tasmania Nursing School which will have a reduced availability of hospital placements? The repercussions to training in this state are huge.
- In 2009 – 2011 this state has had to employee trained and highly skilled nurses through agencies at above wages paid to Tasmanian employed nurses. Millions of $. In a bid to curb this expenditure, active recruitment was under taken, which attracted a number of people on 457 visas. They are competent, trained and willing to work but as on fixed term employment then as of December they will be unemployed and seeking jobs interstate. Recruitment in the future will be tainted by these peoples' experience. They bring families, the children go to school and they become part of the broader community. Investment wasted.
- Deskilling the work force by not recruiting experienced educated nurses has long ranging impact on the health outcomes of this state.
- Building the confidence in the potential workforce to recruit in the future will be harmed to a point where we will not be seen as a favoured employment destination.
- Once again we will have to resort to importing a skilled nursing workforce from other countries.
- If Queensland predicts that they will need 14,000 nurses in 2014 where is our workforce planning predictions?

Consultation and change management processes

- Give people the open frank communication and the ability, authority and funds to manage the change
- The whole current process of health cuts is being shrouded in, innuendo, rumours and denial. People cannot cope with inaccurate Chinese whispers and fear and demonization occurs.

- The CEOs have knowledge but they are gagged by the government. This is not fair or reasonable on the CEOs who have to give the staff the bad news.

Integrating Surgical West and Surgical Central wards at the NWRH (Orthopaedics/ENT/Rehabilitation) has increased the stress levels of all ward staff significantly and is contradictory to standard infection control practices. Where 'clean' (and 'dirty') surgical cases were allocated to designated rooms we now have post-operative patients all 'mish-mashed' in together. Patients having knee/hip and other orthopaedic surgeries are sharing rooms with patients requiring/recovering from gastrointestinal, urological and reproductive organ surgeries. Male and female patients are also sharing ward rooms more often than not. What happened to maintaining (what little) privacy and dignity our patients have while they stay with us? As a ward we have lost some of our transition-to-practice new graduate registered nurses as a result of the cut-backs who have acquired employment in public health interstate and yet there can be upwards from 1-3 casual pool nursing staff on a shift. Nursing staff continue to do double-shifts due to afternoon/night staffing shortages. Some of the nursing staff here have been reduced to tears due to the increased patient numbers and workload. Morale here is very, very low.

I work in general practice. The flow on effect from cuts at the RHH includes risks to patient safety and being unable to follow best practice guidelines for patient care. We now have paramedics who recommend patients are managed in the community because "they will sit in the waiting room" at ED. When patients present with chest pain and a cardiac cause needs to be excluded, monitoring with serial ECGs/bloods is best practice. In general practice we don't have the staff or facilities to complete this care. Our GPs are now actively recommending private health cover to patients, even the elderly and pensioners for them to be able to access quality health care. With the push for support in primary health care/preventative care, then we also need the back up of a tertiary facility for referral.

It is time for us (ANF-TAS members) to Strike. ANF-VIC members have been striking for a pay rise. We are having our jobs slashed and our patients are being forced to wait longer and longer for treatment. Our focus should not be on meetings and parliamentary inquiries to try to come up with ideas about how we (the frontline workers who deliver healthcare) suggest the Government can get back the money they have squandered. Is it really our responsibility to come up with ideas to try to save money? Isn't budgeting what we the tax-payers employed the Government to do and they have bungled it. We do not have too many nurses working and the Tasmanian people do not deserve a sub-standard health care system. We need to stand up in support of our patients and colleagues. Of course in striking we should not deny any of our patients' health care delivery but we need to make a good show of telling the Government No.

LGH/ICU. We are having experienced ICU staff (with critical care certificates) not having fixed term contracts renewed. The explanation for not renewing contracts is 'this position may be required for redeployed' How short sighted. There is no way a re-deployee from a closing ward would be able to take on the duties of a skilled ICU nurse. It takes at least a year of education and experience to become a safe and reasonably competent nurse for this environment. The whisper is we are being rebenchmarked to 9 beds (from 11) as this is evidently part of our budget strategies with the possibility of being reduced to 7 beds.!!!! .At this point in time our occupancy has been 9 to 11 beds, filled with acute admissions(ICU +HDU). Elective surgical admissions to ICU are on average only 1-4 patients a week. We have had to cancel 3 out of 4 elective surgical cases this week. Overtime/double shifts are daily to second daily occurrence at this present time. The expectation that we will need

Less beds, less staff with elective surgical cuts is very unrealistic.

LGH/ICU. We are already working excessive amounts of overtime and they are not renewing all our temporary contracts. The number of staff we have now does not cover sick leave, even if they close beds we will still be short staffed as the patients are likely to be higher in acuity, and because of the budget cuts they will be sicker by the time a bed is available in ICU. These are staff that we have spent 12 months training and are now able to care for moderately sick ICU patients. It is not economical to redeploy staff from other departments to ICU, as they will not be capable of caring for ICU patients, as they will require 12 months of education before they will be useful. We need to keep the temporary staff we have trained.

Hi, just wondering if anyone has considered the following roll on effects in addition to the obvious not enough beds to go around and subsequent reduction in elective surgery?

- the deskilling of specialty nurses ie, the relocation of specialty units without the relocation of their staff, subsequently deskilling the unit and wasting the skills of their nurses.

- the provision of specialty care (or lack of) to patients no longer fitting the criteria for admission to their home unit wards such as those placed under a surgical bedcard for conditions that do not require surgery ie, epistaxis, tonsillitis, ophthalmology corneal ulcers, post obstructive diruesis; and those no longer fitting the three day turn admission criteria to surgical specialties (now high volume short stay) laryngectomy, tracheotomy, nephrectomy, radical prostatectomy major burns, neck dissections, flap repairs... the list goes on. These patients are at significant risk of complications but will be cared for in units that have little or no education and no practical experience in the area.

- the cost of subsequent negligence claims resulting the mobility or mortality of a patient caused by the above both to the hospital facility and the nursing staff who have been placed in the position of having to nurse people with conditions they have no experience in, without the support of skilled staff on their units.

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

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

There are of course a lot of other issues but most have been brought up by ANF already.

If any clarification is needed I can be contacted on 0408547862 or 62396051 or work 62228558

Where is the incentive to acquire specialised nursing skills when inpatient management will be provided in mixed medical and surgical wards; when we have specialised units for care i.e. stroke unit the outcomes improve and readmissions decrease. Doesn't that save money?

After working in the private sector for 25 years, the proposed cuts concern me greatly, not only do we share VMO,s, but also clinical staff eg ICU staff ,.. the necessary to transfer patients between hospitals, the use of equipment eg orthopaedic prosthesis, drug availability. It was only a few years ago that we recruited staff from other countries and paid for their relocation, due to the lack of our own trained RN's. There is already a shortage of GP's. Also where are our graduate nurses supposed to gain valuable post training experience. Let alone the students that are being trained from other countries....

I wish to offer some constructive feedback from observation and experience. These are opinions to which I believe I am entitled to hold, I am happy to hear responses to the contrary should I be proved to be incorrect.

I relation to risk of the changes there has been a lot of staff movements which puts some clinicians in areas they do not normally work both in terms of physical location and clinical skills and in some circumstances leaving less staff to do the same or more clinical load than before. This increases the risk of errors especially as this change within the RHH will need increased educational input and time to up skill and familiarise.

I firmly believe the flurry of activity and planning and implementation has taken the clinicians focus away from service delivery and concentrated on the change management. This has tied up a lot of resource particularly higher management without true consultation with the clinical staff delivering care. I fail to see what the actual efficiencies are with the destruction of the Day Surgery Unit as a separate entity and as a speciality in its own right. As a clinician in this area for 12 years and as an expert nurse in this area, having been called upon constantly to provide advice on change within the unit, I am appalled that there has been little respect paid to this area as a speciality. As a member of the Royal College of Nurses Australia and The Australian Day Surgery Association I feel qualified to make comment on this matter. The changes that have been made as far as I can see have only added extra steps in providing care and result in more patient movement. Some roles which have been introduced I believe have serious implications for patient safety and outcomes that is the role of a handover nurse. If you refer to the ANMC decision making framework, not all of the necessary components have been considered.

Examples of waste and inefficiency continue through internal movement, restructure, and mismanagement of the health budget by the department. Countless hours have been spent planning projects that were never and are never going to happen. One week we are expanding and the next we are imploding like an organisational black hole. The inability of the department to recruit proceduralists has seen unfilled lists and poor management of the resources in place to provide a service that does not exist. A clear example is endoscopy. Providing capital works for new building projects such as the new theatres without the provision of approved funding to run them would appear to me to be a political scoring exercise rather than a true commitment to the health of Tasmanians.

In relation to workforce planning, retention and skill sets, I am farewelling colleagues, have experience a personal loss of job satisfaction and have been sent to an area which is not my speciality and have been more or less stripped of my management duties and leadership role by the change. I feel disenfranchised, demoralised and depressed. I would add into that, undervalued, underappreciated and underutilized as I have not been truly consulted and I have been able to predict all the changes through observation. I knew what was happening only because my years of departmental experience allowed me to read between the lines even when communication was shrouded in secrecy, misleading and deceptive. The effect on the moral of the staff I work with and have worked with has been affected. Job satisfaction has not been accounted for, loyalty or actual skill sets. There has been a lot of what I would call organisational bullying to make things happen. I believe this has been handled abhorrently. Recruitment and retention will be affected by these changes for years to come. I firmly believe there is little or no understanding of what it is that clinicians actually do in the provision of care. I believe department has used the new EBA as a tool for their own devices not to empower nurses and recognise their worth but to constrain the budget.

Better solutions would be to respect the clinician skill set, utilize this resources. Re skilling an already skilled workforce is false economics. Providing the right skills in management and leadership would go a long way in reshaping the service.

Consultation and change management I believe are just weasel words within the DHHS.

The national reform should have had an increased focus through education at the point of care delivery. I do not believe this has happened in a safe or satisfactory manner.

The flow on effects to GP's and aged care will became only too obvious in the coming months as the hospitals fail to be able to provide a service.

I thank you for the opportunity to provide comment.

I wish to make comments about the impact of the Health Cuts onto the Child Health and Parenting Service (CHAPS).

I am very concerned about staffing levels. Any relief staff that we have whose contracts have expired have not have their contracts renewed so if staff are sick, clients are getting cancelled and rescheduled to a later date. We have almost no relief at all which places a lot of pressure on the staff with regard to sickness, annual leave, long service leave etc as we just have to take on the load with no extra support.

New Parent Groups are on hold from January due to staffing levels. New Parent Groups are vital in supporting first time mothers. The groups are empowered to support themselves once the sessions with the Child and Family Health Nurses have ended, this is an example of Primary Health Care. Without the groups, mothers will be isolated, probably require extra appointment times to get the information they miss out from the group and be less supported in their parenting role.

Staff retention is a problem with contracts not getting renewed. It is very sad to have a young, newly graduated, enthusiastic Child and Family Health Nurse not know if her contract is going to be renewed when it expires in the coming weeks. As it stands, a lot of Child and Family Health Nurses are getting closer to retirement age so it is so important to provide opportunities for younger staff members to become permanent in order to develop skills and keep the workforce going into the future.

There has been talk (unsure if going to happen) of CHAPS only focussing on vulnerable families in particular lower socioeconomic families. How can one define who is vulnerable? All families have the potential to be vulnerable when it comes to parenting whether it is complex needs like housing, mental health, economics, violence etc.

Most importantly, the work we do with families now can greatly improve health outcomes for the future which in turn could ease the burden on acute care services. Child and Family Health Nurses educate families about good health and provide early intervention. If we can make changes in the beginning like we do then we will have a healthier population for the years to come.

Hope these comments can help.

You are doing a wonderful job and I notice that it is significant that ANF are the only ones articulating a need for a wider discussion in the planning, implementation and ramifications of any change prior to sensitive and appropriate cut-backs being made.

It appears that the change has been given such urgent priority that a narrow and short-sighted view has been imposed.

The legal implications for the government as employer are significant as fear is cast amongst its employees, services are compromised while employees look to their entitlements and contracts for details which are scrambled and team spirit and hope for the future is compromised.

Good management articulates change in a responsible manner and with consideration for all those involved.

Surgical Central (NWRH) is in chaos. It needs a complete overhaul to accommodate the extra patients, doctors and nurses from Surgical West. Staff need a bigger handover room, more desk space, more chairs, a new storeroom, a larger treatment room, a larger imprest cupboard, a larger pan room, and an extra ward aid. I know where they can find all that without having to spend a cent on refurbishment - it is all sitting empty around the corner on Surgical West!

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

The Area Manager has identified another 4 FTE positions in Adult Community Mental Health to be abolished. Each FTE has a case load of approximately 20 people with a mental illness. Thus the number of people in the North West who have a major mental illness but are not able to be managed appropriately could blow out to 100 – 110 people.

While the cuts to spending on health care in Tasmania has the important and obvious effect of delay or denial of service to patients, at the very least in the short term, it is also prudent to consider the long term effect that these cuts will have on the future of nursing in Tasmania.

The average age of Nurses in 2008 was 45 and continuing to rise (The Age, 2008) and yet in the face of this the Tasmanian government has by its health funding cuts guaranteed to continue this trend as well as accelerating it.

Bed closures have given rise to the need to redeploy permanent Nursing staff from the affected wards to other wards that have reduced nursing staff due to non-renewal of fixed term contracts or the loss of graduate nurse placements. Anecdotally the predominant demographic of the graduate nurse is a nurse whose average age is considerably less than 45 and it should be noted that the graduate nurse contract is also a fixed term contract.

Given that fixed term contracts will no longer be renewed unless there are exceptional circumstances of need the future of nursing in Tasmania faces the following challenges;

- Why would a prospective nursing student choose to study in Tasmania with little chance of a Graduate placement and, in the unlikely event of a placement, no prospect of a job to follow that placement? This will no doubt have a flow-on effect to UTAS School of Nursing.
- Graduate and other fixed term contracted nurses face the decision; remain in Tasmania with likely unemployment or leave. The migration of skills out of Tasmania will be of significant cost to the State economy for years to come.
- Large numbers of nurses that are Tasmanian trained will end up on the mainland. As a preceptor and with a passion for education an attitude of lethargy has been noted amongst colleagues who believe that education of graduate nurses has become a worthless chore since those graduates will be unable to contribute to Tasmanian's health care system.
- The exodus of graduate nurses from the state will result in a future nursing crisis in Tasmania. The crisis begins with the current nurses retiring from the profession while few experienced replacement nurses are available.

I will conclude with a quote from a nursing colleague whose graduate contract is ending in January; "I'm off to the mainland and to Tasmania I will never return!"

No consultation, no warning to SW staff, assumed bed cuts would be done in a sensible and timely manner and across all wards, total devastation to close a whole ward, acute surgical beds, SW also accommodated overflow of Ortho, ENT and Medical.

SW staff not given courtesy of being informed of closure prior to CEO announcement at forum, cruel and callous action indeed.

Alternatives to ward closure…… staff not given chance to make suggestions e.g., close beds across hospital, would have same impact i.e., cuts to elective surgery, reduction in need for casuals, redundancies.

Many risks assoc with putting 36 pts and the staff on one ward e.g., mix of clean/ dirty surgery, and rehab, not enough space for staff to get, check and prepare drugs for safe administration, not enough room for sitting for documentation for all HCW's in the confined spaces.

No sense part 1……State budget cuts….close beds, cut elective surgery…….

Federal govt……. buckets of money pouring in……e.g..accomm units already built, new cancer centre and rehab facility to be built.

Despite no money, still money for fat cats in bureaucracy, no cuts there, in fact whole new layer of management to be installed (THO) with generous salaries to match. Shocking waste of money esp. when we are told there is none.

Elective surgery cuts will have devastating effect on health of Tasmanians. Elective surgery would include e.g. mastectomy or colostomy for cancer, scopes to detect early growth tumours, early intervention and cures. Preventative health jeopardised.

Preventative health measures will take a generation or two to show results. Perfectly healthy people can get sick too. Road and Industrial accidents do still happen.

No sense part 2…….close beds, spend money coping with impact .e.g. increased security for Children's ward staff, duress alarms, new doors, 2 staff at all times. Another e.g. spend some more money on alleviating risk factors on S Central, more doors needed on rehab lounge so handover can be given here because some staff having to sit on the floor, as present room not big enough to hold extra staff.

Cuts to NW coast not fair. Already working efficiently.

Cuts to frontline health are unfair, unacceptable and will result in deaths.

Let it be known that nurses will continue to campaign vigorously and relentlessly against these and any further threats to the health and welfare of Tasmanians.

Physician preferences are impacting on the outcomes of tender processes – Endoscopy tender not awarded due to political involvement.

Physician preferences dictate the equipment purchased rather than the service delivery that the equipment is required for. The financial cost of this is astronomical.

Purchase of goods broken down so as to circumvent Treasury Instructions relating to the procurement of equipment i.e. bariatric bed for the SAHS $68,000 approximately but no quote and broken into separate items, Non invasive ventilator x2 machines for DEM ordered separately to avoid process. A review of recent LGH and RHH procurements would demonstrate this.

A centralised medical equipment procurement would demonstrate cost savings but the Area health services would need to agree on the outcomes at this stage this has been refused.

Leased medical equipment often extended contrary to Treasury extensions, life cycle of equipment contrary to BEAG and ATO recommendations thus impacting on the 75% rule. Business managers need to attend to procurement processes earlier to mitigate extension requirements. Review of previous medical equipment leasing arrangements would demonstrate this, Endoscopy equipment; analysers etc. lease payments represent cheaper option to the business managers rather than outright purchase and time spent on that process. However in the long term it is more expensive. Many leases represent Finance leases as they are not non cancellable (need to repay full lease amount), refer 2010 contract.

Replication of resources shall see reduction in catchment areas impacting on activity and funding. Utilisation of mobile services and offering specialised clinics to those areas would mitigate the need to appoint staff on a permanent basis and also eradicate the need to purchase that equipment.

Evaluation processes during a review of request for tender delayed due to the non conformity of the Area health Services, if it is not the product that the Area Health Service wants, the obstructive behaviour starts. Staff are "leant "on to provide different outcomes, reports are altered.

One reason that our health budgets are perennially challenged is that every piece of equipment or consumable marked for 'health' is priced like it was gold-plated, and the price tag increases exponential year on year. This unsustainable situation could be countered if governments would combine with some of the intellectual-capital that is more-or-less at idling in our Universities, plus, perhaps, some local business acumen, in order to build a home-grown, self-sufficient, import-replacement health-equipment industry.

Tasmania is the poorest state of Australia with the nation's highest rates of cancer, heart disease and diabetes. It also has the lowest number of doctors per capita in the nation. Prior to 2011 the state's health care system was described as mediocre, with long waiting lists for elective surgery stretching to years. Waiting times in our emergency departments had blown out of control and assistance from community mental health services was only available to those in most dire need. People presenting at accident and emergency often had long waits for treatment. From this already stressed system it was decided to cut $100 million. $60 million is to be cut from elective surgery over three years and one quarter of public hospital beds in the state will be closed at a time when occupancy rates are between 97% and 100%. Mental health services are also being slashed.

The Tasmanian Government has not made a case of wastage or mismanagement in the health care system, so we must conclude the health cutbacks are simply a political decision based on government priorities. Expenditure on public health is an investment in the future. We must not let some unjustifiable desire to avoid a budget deficit stand in the way of sharing the cost of this investment with future generations through incurring debt.

These cutbacks to health care must be stopped, because the Government of Tasmania will inevitably cause the deaths of people they were elected to care for. What kind of perverse economic or political system decides the most vulnerable members of our community have now become dispensable simply to 'balance the books'?

This behaviour is even classified as an illness itself. This extreme economic rationalism is often called 'psychopathic'. There is no place for the economic rationalisation of fundamental human rights in a civilised society. Government officials have invented mechanisms to disconnect themselves from the responsibility of their actions but they must be held accountable.

It is no accident that the amounts of money that were siphoned away from public health are the same amounts now being forcefully recovered at the expense of the most vulnerable in our community. To think for one moment that the duty of care accepted by anyone that stands for public office has now become a discretionary expenditure that can be shifted to more popular or exciting activities is an act of extreme ignorance. To hope that gambling public assets on private corporations and commodity futures will somehow benefit the whole community is naive and outside the mandate of the public official. Economic reports commissioned by the health unions show that the loss of jobs in the public sector will have a flow-on effect into the private sector, further depressing the economy. As skilled health care professionals are forced to leave the state with their families, it will be very hard to recruit them back in the long run, further exacerbating and extending our health care crisis into the future.

The system is dysfunctional and must be reconstructed with health delivery the main priority. We believe that the Tasmanian Government must now accept their responsibilities and realise they have lost their way. They must act immediately before more lives are lost and the health system itself crashes.

Actions that must be taken immediately by the Government include:

(1) Reverse the health cuts so that there is no frontline loss of services including no bed closures and no decrease in elective surgery.

(2) Re-vamp all health services in Tasmania including Mental Health, Drug and Alcohol, Disability and Child Services.

(3) Develop preventative holistic health strategies and put them in place within six months alongside and working with the re-vamp of acute care services

(4) Minimise the health bureaucracy and make it more accountable to the directions and input of grassroots clinical staff, patients and families.

Questions we believe need to be addressed as matters of extreme urgency include:

1. Management practices

Despite government denial that there are serious management problems the fact is that service providers and receivers have pointed to serious bungling by health bureaucracies, resulting in inefficient use of resources and prolonged suffering by patients.

2. Environmental and Preventative Health

Campaigns to reduce the exposure of Tasmanians to toxic and other unhealthy substances could save money in the longer term. It also needs to be recognised that there are many social and environmental factors affecting Tasmanians' physical and mental health. These include over-use of pesticides, irresponsible use of dangerous substances such as asbestos and materials used for food storage, psychological stress brought about ultimately by intergenerational poverty, dietary problems through a combination of poverty and inadequate education, alcohol abuse and many others.

3. Equipment and Services

The geographic distribution of high-tech medical equipment and specialist services needs to be looked at in an open public discussion, involving health workers and consumers. This must also include discussion of the merits of retaining regional hospitals to provide basic care.

4. Budgetary Priorities

Health funding in Tasmania today cannot be seen as separate from the world economic situation. Until governments take notice of those (from acclaimed economists such as JK Galbraith to the leaders of the Occupy movement) who have been advocating the abandonment of an unreasoned obsession with budget surpluses and the imposition of increased taxes on the super-rich, as well as government funded stimuluses to the economy, there will not be enough money for public health and the fostering of a healthy, socially just society. We join with the health workers and Tasmanians from all walks of life who are raising their voices and calling for this.