Australian Nursing Federation
(Tasmanian Branch)

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

Appendix D
Tasmanian Public Sector Cost Saving Initiatives 2011 - ANF Submission

December 2011

Tasmanian Budget Implications

Tasmanian Public Sector Cost Saving Initiatives

ANF Submission

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AUSTRALIAN NURSING FEDERATION

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

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

The ANF is a member of the South Pacific Nurses Forum and is affiliated with the Australian Council of Trade Unions (ACTU), the Australian Council of Social Services, the Public Health Association of Australia, the National Rural Health Alliance, the National Aged Care Alliance, the National Medicare Alliance, the International Centre for Trade Union Rights and the Australian People for Health, Education and Development Abroad (APHEDA).

The ANF plays a significant role in creating positive change for Tasmanian nurses, including achieving improvements in working conditions, wages and a range of other issues. The ANF Tasmania is the fastest growing branch in Australia, with currently around 6,000 members; we look forward to continuing to strengthen our presence in Tasmania, and in making change for nurses working across all sectors, in all parts of Tasmania.

BACKGROUND

ANF attended a meeting with representatives of DPAC and other public sector unions in February 2011 to discuss the implications of budget concerns within the Tasmanian Public Service. ANF has also met with Government representatives, including the Hon. Michelle O'Byrne, Lara Giddings (Premier and Treasurer); and other public sector unions to discuss the specific government proposals in addressing these budgetary concerns.

ANF provides this Tasmanian Public Sector Cost Saving Initiatives submission. In order to assist in the preparation of this submission, ANF has consulted with members and sought guidance from ANF Representatives, Branch Council and Branch Executive. Unfortunately many of the suggestions have some initial implementation costs (not always significant) and will not produce immediate cost savings rather will result in on-going cost reductions. ANF have raised several of these suggestions in the past but with no resultant action.

At the latest meeting with the Minister, ANF proposed that a joint union sub-committee with ANF Reps/DHHS officials should be immediately implemented to assist in efficiency identification and implementation. Respective committees are to be

implemented at each Area Health Service with Union representation. Nurses working 24 hours a day in hospitals and primary care settings are best placed to identify efficiencies.

1. Management and Human Resources (HR)

1.1 Invest in managers. Appropriately trained managers will understand how to performance manage staff; manage rosters; create and work within business rules; and work within budgetary requirements. This will result in wards running more efficiently; more productive and secure staff; and will have a flow on effect of improving recruitment and retention. Initial investment will provide long-term results.

1.2 Give managers budgetary control with Business Manager support and remove prescriptive establishments: ie allow managers to staff to an skill mix FTE made up as they deem appropriate.

1.3 Enable capped purchasing (to a preset limit) to utilise sales and opportunities. Ensure timely delivery of budgets to ensure the flow on budget money is available 1 July.

1.4 Decentralise HR and have operational HR staff working in the clinical environment/workplace. This would provide managers with support in regard to managing expenses such as overtime, casuals, and agency staff.

1.5 Pay office remains an obstacle and their unilateral interpretation causes inefficiencies and time for Managers.

1.6 Filling positions with permanent staff is a cheaper option than using casuals, paying for overtime and agency staff. Ensure timely recruitment, current business controls will result in additional costly overtime due to inability to fill vacant rostered shifts.

1.7 Challenge each manager to make a 1% saving in each unit. Provide them with the budgetary support and authority to achieve this safely.

1.8 Acting Roles continue to restrict continuity and productivity. Audit the number of acting/HDA FTE and review at sub- committee.

1.9 Abolish the multiple employment policy. Permanent employees who have part-time contracts but work additional hours on a regular basis (up to full-time hours) are employed under the multiple employment policy. This requires any additional hours (above their first contract) to be paid at the 20% loaded rate, rather than paid at ordinary time and accruing additional leave (to prevent wards/units paying the costs of leave accruals). This is a false economy as they remain Public Sector employees irrespective of ward/area additional hours are worked.

1.10 Project/policy positions must be audited and a report tabled to be discussed with ANF to identify any potential reduction.

Senior Executive & SES - Includes Bands 9 & 10:

- No increase in numbers in any agency
- Assessment of all entry level SES positions to be reviewed on vacancy to establish whether position is required
- Targeted reduction of SES offices in areas where there are disproportionate numbers

2. Systems

2.1 All patients admitted to Hospital should have a planned date for discharge. This could be publicised on a whiteboard and colour coded to ensure high visibility for planning.

2.2 There are no auditing processes at present to monitor non-stock ordering, which results in significant waste. Statewide ordering is still not happening, eg pens.

2.3 Implement a system of monitoring when private hospitals 'borrow' equipment from the public system – and ensured they are billed for this, along with any disposables that are utilised or cease practice

2.4 If hospital pharmacy, allied health and radiography provided 24 hour coverage or had an improved on-call service this would prevent unnecessary admissions or reduce length of stay. Alternatively there should be a cost analysis between the expense of providing additional cover in these services compared to increased length of patient stay/increased admissions.

2.5 Implement a Nursing Clinical Information System to ensure streamlining of processes, prompt action of variation and length of stay and implement research /evidence based improvements in systems and delivery of care. Introduce electronic progress notes rather the hard copy and scanning.

2.6 Ward rounds should be planned and occur at set times to ensure all required staff can attend. This will improve communication in regard to patient requirements (including required diagnostics), expected date of discharge etc. Thus improving efficiency and ensuring timely discharge.

2.7 Ensure only 2 days of discharge medications are given to patients discharged back to their Aged Care facilities as they will be given their medications from disposable administration packs. The current supply of 30 days of medication are thrown out at the Nursing Home.

2.8 Implement nurse-led discharge. Registered Midwives currently have ability to discharge and this has proven efficiencies.

2.9 Implement lean systems. The key areas of wastage in hospitals are waiting (for beds, for test results); queues (patients queuing for a test); errors (wrong procedure, medication errors); transportation (moving patients, moving equipment); motion (staff searching for equipment, paperwork, outlying patients); over-processing (unnecessary tests, duplication); overproductions (referrals made to early). Implement processes to minimise this and this will not only increase patient flow, but reduce budgetary waste. Flinders hospital in

South Australia has a good model and has implemented this effectively. Victoria DHS has also implemented an excellent framework. Fund project positions to ensure savings.

3. Clinical Diagnostics and Disposables

3.1 Each patient should be benchmarked to determine expected costs in regard to length of stay (cost of each bed day), diagnostic tests, disposables etc dependent on admission. There is currently a policy of risk aversion and ordering all diagnostics rather than limiting to specific testing. Publicise the outcomes of each provider and ensure transparency. It would be possible to have 'levels of tests' that can be ordered by various medical practitioners, eg Interns might be limited to 'routine' tests only, Registrars to a 'higher level' etc.

3.2 Maintenance of equipment and standardisation of equipment – Each ICU has different equipment which is not compatible across state.

3.3 Increase the use of generic medications in hospitals. Pharmaceutical supplies should be centralised to ensure reduced costs for larger orders and consistency across the state.

3.4 Oncology drugs are extremely expensive (up to $3000 per treatment). They often have to be discarded if the patient is not well enough to have treatment on that day or not able to access a bed. More efficient screening of the patients' diagnostic results and health will reduce this waste.

3.5 Improved hours and access to diagnostics and pharmacy currently services close at 14:00 Sunday at RHH and LGH closes from Saturday 12:00 to Monday 09:00. We need seven day a week coverage 0800-2000 hours to reduce length of stay.

3.6 Reduce the amount of inappropriate surgery. Age, quality of life and risk factors should be considered prior to surgery being undertaken. Eg It has been reported that a 91 year old patient recently had a second operation at RHH, 96 year old post operative recently in LGH Intensive Care Unit.

3.7 So much stock is ordered based on Doctors 'needs' or preferences. For example they will only use one brand of joint for joint replacement surgery. If each surgeon at each hospital only uses one brand, each hospital has very expensive joint trays that often expire prior to their use.

3.8 All stock items should be labeled by non nursing staff with their price per unit in the store rooms. For example a 1 litre bag of fluid is cheaper than a 500 ml bag of fluid. However there may be times when it is clinically more appropriate to use the smaller bag. If staff are made aware of unit pricing they will be more conscious about the use of these items whilst still providing optimum care to the patient.

3.9 Wound dressings should be reviewed by wound specialist or consultant prior to removal. Early removal can mean that a dressing that costs thousands of dollars is removed and replaced unnecessarily because the doctor wants to review the wound.

3.10 Review the replacement of linen. Of course if linen is soiled or if there is increased infection risk it should be replaced. But often linen is discarded unnecessarily – resulting in additional laundering costs.

3.11 The cost of disposable pans etc should be analysed vs. the cost of disinfecting the current reusable items.

3.12 Use local hotels rather than acute beds for pre and post acute care. Outreach services could be broadened to reduce inpatient days. Issues with transport and bed access remain with an inability to transfer patients back to their home region causing delays. Independent patients requiring minimal daily clinical intervention in hotel beds will reduce the cost of additional inpatient days.

3.13 If private patients are being cared for in public hospitals then they should not have a choice as to whether they use their private health insurance. The DHHS should cover any 'gap' costs and excesses they would not incur if they were admitted as a public patient.

3.14 Implement recycling boxes (plastics, glass, cardboard etc) and reduce costs of rubbish removal. Ensure appropriate use of 'yellow infectious' bags which are often filled with normal rubbish but, because of their 'yellow' status need to be burnt or buried incurring extra costs.

3.15 Each area manager to display 'price', the cost of equipment on the shelf so staff can make informed decisions about what equipment (if any) to use – it is difficult for staff to be 'cost-conscious' in the absence of information about costs. This is not a nursing role to action and monitor change in prices.

4. Transport and Travel Expenses

4.1 Cease the use of corporate travel as it is usually more expensive than other options. Those employees that must travel should use the cheapest flights available. No employee (or 'corporate visitor') should travel other than in economy seats unless they are prepared to pay the difference.

4.2 Book accommodation on discount websites such as "Wot if" or "Last Minute". Individual hotels often have reduced rates when booking directly with them, but closer to the date.

4.3 There should be a Public Sector bus that runs between Hobart and Launceston to minimise the cost of intrastate travel. Additionally car pooling should be promoted. It is not unusual to see several DHHS cars with only one person despite the fact that several people are going to the same meeting.

4.4 If utilising the services of interstate/overseas consultants/health professionals the cost of a domestic flight and reasonable accommodation is all that should be covered. All future corporate/visitor travel should be declared and displayed on the government website.

4.5 For shorter journeys promote walking and cycling as an alternative to politicians and senior government employees being driven around town. Install bike racks at major hospitals and centres.

4.6 Significantly reduce overseas trips by State Politicians or senior government employees funded by tax payers and openly publicise reports and benefits from such trips.

4.7 Increase the use of the Telehealth or like videoconferencing facilities for both intrastate and interstate communication.

4.8 When staff taxis are provided, co-ordination or pooling of the service would ensure there are not multiple taxis travelling to the same area with only one staff member in each taxi.

4.9 Monitor the use of patient travel to and from treatment. Often they receive cab-charge vouchers when they have family or friends that can assist them. It is seen as an 'entitlement' rather than for those with no other form of transport.

4.10 Transport of patients on return to their home, who may be incapacitated, would be better supported by an internal transport system rather than the use of public transport.

5. Employment Arrangements and Employment Packages

5.1 Offer permanency of employment to staff. If agency staff are required, then local agencies should be utilised prior to interstate agencies which results in additional costs of accommodation and travel, eg current agency nurses receive higher pay than the permanent nurses.

5.2 Reduce the number of locum doctor positions and replace with staff specialist positions. It has been reported that Mental Health locums cost $10,000 week.

5.3 Doctors can presently be employed as a full-time medical officer and have their own private practice. There should be some limitation around this and all day hours should be worked in public. It has been reported that public sector RMO's assist in private theatre lists during work hours.

5.4 Medical Staff undertaking surgery on private patients in the public system (because of the unavailability of specialist equipment in the private sector) should be obliged to ensure early transfer of the patient back to the private sector once the patient conditions so permits.

5.5 Employment packages offered to doctors should be reviewed. Including reviewing the timeframe for the replacement of doctors' laptops, phones and cars. At present they are being provided with BMW, Volvos and Subaru's (for example) and there is no accountability for open petrol credit cards.

5.6 Mobile phones provided by the DHHS should be standard base models, with capacity to make and take phone calls with exceptions for those approved to have email activated models.

5.7 Abolish the multiple employment policy. Permanent employees who have part-time contracts but work additional hours on a regular basis (up to full-time hours) are employed under the multiple employment policy. This requires any additional hours (above their first contract) to be paid at the 20% loaded rate,

rather than paid at ordinary time and accruing additional leave (to prevent wards/units paying the costs of leave accruals). This is a false economy as they remain Public Sector employees irrespective of ward/area additional hours are worked.

5.8 Limit the $10,000 education and research annual grant given to medical staff.

6. Executive, Government and General Administration

6.1 Monitor and reduce the amount of paper used throughout the public sector. Print on both sides of the page.

6.2 Government to cease funding interstate sporting teams and arts events.

6.3 The dining room in Government House to be run as a profit neutral enterprise.

6.4 Charge full price for meals for non staff at cafeterias in all hospitals.

6.5 Encourage all staff to turn of electrical items when not in use such as lights, computers, heaters etc. Introduce motion activated lights in all corridors and non-essential areas (eg lecture theatres, toilets, cafeteria areas etc).

6.6 Encourage people to use the stairs instead of the lift by advising them how much power costs are for each floor travelled to by this method. This in turn creates a healthier workforce.

6.7 Clear leadership and commitment by Politicians through demonstration of reduction of “minder” positions, senior Executive positions and non essential bureaucrat positions. SES positions to be made redundant, not reclassified.