HANSARD

NOVA SCOTIA HOUSE OF ASSEMBLY

COMMITTEE

ON

PUBLIC ACCOUNTS

Wednesday, May 6, 2015

LEGISLATIVE CHAMBER

Nova Scotia Health Authority

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Public Accounts Committee

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[Mr. Terry Farrell replaced Mr. Brendan Maguire]

In Attendance:

Ms. Kim Langille
Legislative Committee Clerk

Mr. Gordon Hebb
Chief Legislative Counsel

Ms. Nicole Arsenault
Legislative Counsel

Mr. Terry Spicer
Deputy Auditor General

Ms. Evangeline Colman-Sadd
Assistant Auditor General

WITNESSES

Nova Scotia Health Authority

Ms. Janet Knox, President and CEO
Ms. Carmelle d'Entremont, Vice-President People
Ms. Vickie Sullivan, Executive Director, Central Zone Operations
Ms. Mary Ellen Gurhnam, Executive Director, Learning, Central Zone

House of Assembly
Nova Scotia

HALIFAX, WEDNESDAY, MAY 6, 2015

STANDING COMMITTEE ON PUBLIC ACCOUNTS

9:00 A.M.

CHAIRMAN
Mr. Allan MacMaster

VICE-CHAIRMAN
Mr. Iain Rankin

MR. CHAIRMAN: Order, I call this meeting to order. We have with us today the Nova Scotia Health Authority to discuss Central Zone staffing. I would like to begin with introduction of members on the committee, beginning with Mr. Farrell.

[The committee members and witnesses introduced themselves.]

MR. CHAIRMAN: Ms. Knox, you can begin now with your opening comments and we'll follow that with some questions.

MS. JANET KNOX: Thank you very much. Good morning and thank you to the members for inviting us here today. On April 1st nine of our province's former district health authorities came together to form the Nova Scotia Health Authority. We have come together with the unique opportunity to focus on the health of Nova Scotians. Together we will create possibilities, find new ways of delivering our services and maximize the current work that we do. Together, with our communities and partners in the health system, we have a great opportunity ahead, focusing on the long-term health outcomes for the people of Nova Scotia.

As we work to achieve this reality, we will also focus our energy on creating a workplace where our teams feel supported to bring their very best to work every day. We are the largest employer in the province with more than 23,000 staff. People are our greatest resource. Our priorities are to ensure that we have a skilled, interdisciplinary workforce and a safe, healthy workplace so we can provide the quality care and service that is required of us. Our workplace also accounts for the greatest portion of our spending so it's critical that we use this important resource, our people, efficiently and effectively.

The Nova Scotia Health Authority consists of one specialty hospital, the QEII Health Sciences Centre, in Halifax; nine regional hospitals throughout our province; 35 smaller sites in many community-based locations. We are working together to achieve excellence in health, healing and learning.

Providing health services is a complex business, in terms of the needs of the patients and clients and our communities and also the coordination required to have the right people with the right skills to meet the demand of care at any given time. Therefore, our approach to staffing must allow the flexibility to respond where there are surges in volume or an increase in the complexity and acuity of the patients we serve.

The health system employees who do this critical work represent more than 200 different roles. Their work is covered by more than 50 collective agreements that have been negotiated with our partners and four unions. It is extremely important that we have an environment where our teams have the tools and equipment they need to safely perform their work and are supported through the physical and mental demands that are a reality in a workplace such as ours, so we will take a great focus on our people and our workplace.

Nova Scotia, like many provinces, faces demographic challenges. We have an aging population and we have an aging workforce. That is a reality across many sectors so competition for workers increases as the working age population decreases.

Nurses comprise the largest segment of our regulated health workforce. According to the Nova Scotia College of Registered Nurses, the provincial registered nursing workforce supply has been stable, at around 10,000, since 2011. In our Central Zone, our present nursing workforce includes just over 2,700 RNs and 630 licensed practical nurses. All other professions in the workforce in Central Zone total about 1,600 staff. The number of RNs in regular full-time jobs has been increasing, especially in the younger age group, and the number of new graduate RNs entering the workforce in the province has shown a general upward trend in the past decade. In 2014, 90 per cent of RN graduates in Nova Scotia were still employed in the province one year after graduation. The majority, 92 per cent of them, are securing permanent jobs.

That being said, we will be facing increased retirements in the coming years as nurses age. A large percentage of the nursing workforce is nearing potential retirement age. Last year, 46 per cent of RNs in Nova Scotia were over the age of 50. Our new grad and older nursing numbers are increasing, leaving the middle-age cohort decreasing. This

means that as our older nurses leave it's a challenge to fill vacancies, particularly in specialty areas such as ICU, emergency departments, and operating rooms, as they can really not be filled by less-experienced new grads. We have been monitoring these trends and planning for the future. Health human resource planning requires a multi-pronged strategy.

Recruitment continues to be a priority, but retention is just as important. It is why we continue to focus on creating a healthy workplace focused on safety for all from a provincial perspective. We continue to build internal capacity by supporting new graduate nurses through a number of initiatives, focused on integrating them into the workplace and developing their skills to work in specialized areas of care. We also continue to identify current and future workforce solutions through strategic partnerships with our universities and the Nova Scotia Community College. There are three key strategies in planning our staffing: the use of consistent scheduling practices; leveraging information technology for better real time data for decision making; and optimizing different staffing models and building staff capacity such as the creation of a nursing resource team.

To be more efficient we want to have registered nurses working to their full scope of practice, and other professionals in the health care team making the most effective use of their respective skills - all based on the needs of the patient population. Despite careful management of our human resources and a focus on ensuring the health of our workforce, we experience staff illness and need to fill shifts to maintain safe levels of care - and temporary vacancies such as maternity leaves can be more challenging to fill than full-time vacancies. When necessary, we cover those staffing needs by either using our own staff on overtime or third party staffing agencies. Overtime costs have fluctuated since 2011 for nursing, while purchase service costs peaked in 2013 for nursing staff and in 2011 for non-nursing staff. Both have been declining since.

With better provincial collaboration we are optimistic that we can reduce the use of overtime and third party services in the future as well. Above all we should note that in addition to the management of our workforce, the actual work we do is meant to improve the health of our population and reduce the need for hospital-based care. An example from Central Zone is work to ensure that as many patients as possible are receiving appropriate care at home or in long-term care rather than in hospital beds. Those numbers are the lowest they've been in years. Our vision as the Nova Scotia Health Authority is to achieve healthy people and healthy communities for generations.

I thank the members of the committee for their interest in the Nova Scotia Health Authority. I would also like to thank all our staff who have put in many years to care for the people of Nova Scotia, or who are early in their careers driven by compassion and a desire to make a difference. Our new organization will consider the needs of the whole province. We will plan provincially, and implement locally in order to meet the demands for care and service of Nova Scotians in ways that make sense in their local communities.

We would be happy to answer any of your questions. Thank you.

MR. CHAIRMAN: Thank you, Ms. Knox. We will begin with Mr. Houston for twenty minutes.

MR. TIM HOUSTON: Thank you, Mr. Chairman, and thank you, Ms. Knox, for that introduction. I appreciate it.

How many doctors would be required to fill the doctor shortage in the province?

MS. KNOX: I don't actually have that number in terms of the doctor shortage but what we can say is we have a process for replacement of physicians in our province that has to do with looking at what the needs are. We have recruitment going on all of the time so the process is very streamlined in terms of identifying the need, identifying the resources that we require to support that physician, and then recruitment.

MR. HOUSTON: Would you say there is a doctor shortage in the province?

MS. KNOX: No I would not say that.

MR. HOUSTON: So you think, you believe that there's a doctor for every Nova Scotian?

MS. KNOX: We have areas of need in pockets around the province and we are in recruitment of those needs. I could ask our vice-president of people to provide additional information.

MS. CARMELLE D'ENTREMONT: Just to comment - the overall numbers of physicians in Nova Scotia fare fairly well when we compare to national averages. Some work that was done with the Department of Health and Wellness in collaboration with employers in the province a few years ago looked at the issue being - it's not always about the number, it's about the mix and distribution, the mix of the physician workforce in terms of percentages of specialties versus general practitioners, for example, and how they are geographically dispersed across the province.

From that perspective there are some challenges in certain areas regarding access to general practitioners. Again, the strategy is really looking not so much at the total number but looking at the health needs of the population, the services we wish to deliver and then whether or not we have the right mix and distribution geographically to meet that need.

MR. HOUSTON: Do you see yourself as playing a role in getting the resources distributed properly across the province?

MS. KNOX: Absolutely. Our process will be to plan provincially and it really does help to have that opportunity to look at the whole province. In our journey around the province talking to physicians, there's great interest in looking at how we can collaborate

across what would have been the previous district health authorities. There was interest in that from the physician perspective, in terms of how they support each other in specialty services, for instance. Then our planning with primary health care, which we have said, we are stepping out with primary health care so community-based care in local communities to be the foundation of our health care system. So family physicians are very important and integral to that work and they will work with other practitioners.

Our model needs to look at what is the collective of the multi-disciplined team that we need for local communities, which will impact how many physicians we have in certain places as well.

MR. HOUSTON: Sure. In terms of giving the doctors the tools and equipment they need to do their job properly, are there many so-called hospitalists across the province and is there a need for more of them?

MS. KNOX: We have areas where we use hospitalists in hospitals providing patient care. That is a growing trend across the country, in terms of how we provide in-patient care. We will be exploring that model to see which the best approach is for our province but I can say that it is growing. It is one way to determine that we will have consistent coverage of in-patient care for our people.

MR. HOUSTON: It's probably a way to allow the family doctors to focus more on their patients and their clinic and maybe on some of the preventive stuff as well. How many hospitals in the province have a hospitalist?

MS. KNOX: Actually, I can't tell you exactly, I'm not really sure.

MR. HOUSTON: Is it most of them or just a few of them?

MS. KNOX: I would say a few of them. That would be mostly in our regional hospitals. We have 34 sites that have beds and we have nine regional facilities so the hospitalist programs are in our regional facilities and in the former Capital Health QEII Health Sciences Centre.

MR. HOUSTON: Thank you. I just want to talk quickly about the consolidation of the district health authorities. That's something that was talked about for quite a while and even quite a while before you were on the job, I guess. When you came into your role was there a plan sketched out as to how the consolidation would happen? What kind of planning had been done around the consolidation of the district health authorities before your arrival?

MS. KNOX: There was a lot of planning. The previous year, beginning in about May 2014, a transition team was formed under the leadership of the Department of Health and Wellness with co-leadership; in fact my colleague Carmelle d'Entremont was at the Department of Health and Wellness at the time. She was the co-lead so we'll ask her to

offer some because she lived it, and one of my former colleagues, Pat Lee, who was the CEO of Pictou County District Health Authority, co-led that process.

I entered in as the CEO designate later, at the end of September. So the whole process in terms of the transition planning was to determine what needed to be done so that we could stand up an organization on April 1st. There were streams of activity with an opportunity where we could use all the evidence that was available to us from anybody else in Canada - people are very open to sharing their experiences - and in other parts of the world. It was an evidence-based exploration of what the things are we that need to do to merge nine organizations and to develop an organization that can move forward, planning provincially and focusing on community needs.

When we began the major reorganization for April 1st the amalgamation of the nine districts was to have one administrative team. The major change that stepped out on April 1st was one executive leadership team as opposed to nine. As we began on April 1st the changes to our service delivery - there were no changes.

MR. HOUSTON: One of the main purposes of the consolidation was to provide administrative savings. Do you have an estimate, as we sit here today, as to what those savings will be from the consolidation? We have heard differently from the Legislature. One time we heard $5 million; we've heard a million-ish, and we've heard different numbers so I'm wondering, as we sit here today, what is the estimate of the savings from the consolidation?

MS. KNOX: The estimate is $5.5 million less for the administrative team and that will be carried forward. We will not be spending that money. That's gone, and so that is real savings in the system and as we move forward now, planning how we provide services in this province, constantly we will be looking at how we streamline our organization because we had nine of everything in terms of how we led the organization.

MR. HOUSTON: So the $5.5 million, that savings has already been realized?

MS. KNOX: Yes.

MR. HOUSTON: You said realized and gone. Was there ever any discussion to taking the savings from the administration portion and reinvesting that into front-line care? You referred to it as being gone. Is it still money in the budget?

MS. KNOX: That was the savings for the change from the nine to one and so we will end up with a budget that is minus that, and as we move forward, our efficiency activity as we plan our services will be our opportunity to reinvest in service.

MR. HOUSTON: So the money to be reinvested in front-line care will be the next round of savings, that's the plan. So the $5.5 million, when we saw the Health Budget it

was up just a little bit, it was pretty stable over last year, and in keeping it stable there was $5 million that was saved from the administration.

Were there people who were let go as part of this process, who received a severance package and who were then immediately rehired into another role in the new administration? So people who were let go, received a severance, and immediately rehired into a similar job, did that happen with anyone?

MS. CARMELLE D'ENTREMONT: There were notice letters given to over 70 people and approximately 29, is the number I believe, were rehired. Those individuals would not have benefited from a severance package and a reoffer. Their notice letter would have been rescinded if they were successful in receiving employment, and of those who left the system, not all of them would have been eligible for severance. That is dependent on many factors, including if they had a time limit to contract currently, and what the notice period was, and whether or not their notice had expired, but there were some severance costs incurred.

MR. HOUSTON: Okay, thank you. And the severance cost I think was about $4.8 million, but that was purely for people who - okay.

So in terms of the restructuring of the administration, does everyone know, in the various hospitals now, like who is in charge, I guess? One thing I hear is that people don't really know who the go-to person is. For example, who would be the go-to person for the Aberdeen Hospital?

MS. KNOX: I'll ask Carmelle to help us describe our process that we went through to make sure that every single person in the organization would know who their go-to person was.

MS. CARMELLE D'ENTREMONT: There was an activity that was undertaken to try to ensure that, at the management level, managers and directors knew who they were reporting to - you can appreciate once you remove a certain level of administration that the other positions don't automatically line up in the same way. So there was robust planning to look at who reported to positions that were no longer there and how they aligned with the new administration.

There was also work done to look at site leadership roles. That was a commitment that was made early by the organization that each site should have a leader. It is typically a health services leader with another portfolio, but who would also have some responsibilities at that site level. So in the process of confirming site leadership for sites, in some cases there have been interim appointments while we can confirm in the future who that role would be.

Then ultimately at the zone level, we do have zone operation executive directors of which Vickie Sullivan is one for the central region. They serve as overarching coordinators for the service delivering the operations within that geographic territory.

MR. HOUSTON: Is there much communication to Nova Scotians as to - I know in Pictou County everyone knew that Pat Lee was kind of the person, and that's comforting when people know who is in charge - right? I think there's still a lot of confusion as to who is in charge. I don't know if there has been a plan to communicate to Nova Scotians or if there will be, to give people some comfort as to how things are operating.

MS. KNOX: I'll start. We did have a plan to communicate with all the stakeholders and the communication came out of the executive directors' offices for the zone, to make sure that foundations and auxiliaries, mayors, the folks who normally would be the connection to, that site leader would know who to call.

We established the information, also what the telephone numbers were, who to call. So we have done some of that. I would say to you that it's quite likely that we will continue to need to do more and more of that because change is challenging when you have a relationship with one specific person. So I thank you for that.

We made a very conscious effort to have a full-blown communication strategy, but we will need to continue to do that - we know that.

MR. HOUSTON: Did you say who the go-to person is for Pictou County now? Who is the person that is . . .

MS. KNOX: I don't have the name.

MR. HOUSTON: Okay. In terms of the doctor situation, I'm hearing about different issues they may have. I know that at the Aberdeen we have a very good ortho-specialty clinic there. One of the frustrations there is the cancelled surgeries because there's a lack of dedicated beds at the hospital, so that's why I was asking about the hospital situation because when you have bed shortages, I'm sure there's sometimes some pressure on a family physician who knows everything about the family and maybe there's a person who is in the hospital that for whatever reason that family doesn't want that person discharged just yet, maybe it would be better if they were discharged on Monday.

All these things are occupying beds in the hospital. I think there is evidence that shows that hospitals discharge people - get them in and out of the hospital - quicker. In Pictou County at the Aberdeen, that situation is complicated as well by a lack of dedicated beds for the ortho team. They might schedule a bunch of surgeries, come in in the morning, and find out some people were admitted overnight and there are no beds, so they're sending people home. What are the thoughts on dedicated beds in the various hospitals for these types of specialties to help address the wait-times?

MS. KNOX: Thank you very much for the question. I'll start, and Vickie may want to add to it. This will be one of the issues that we will look at as we plan our services from a provincial perspective. We have various experience around the province where we have dedicated surgical beds in one institution and it seems to work for that institution in how the team works together, and in others we have not. So it will be one of the issues that we need to explore.

In the final analysis, what our goal needs to be - when we have a service, we want people to get into it in a timely fashion and to move through the system so that others can access it as well. It gives us the opportunity to really look at - the orthopaedic service is a good example of looking provincially at where all our beds are and how we make sure that they're available in a timely fashion to continue this service. I'll just ask Vickie, because she has experience with some of this.

MR. CHAIRMAN: Ms. Sullivan.

MS. VICKIE SULLIVAN: I can only speak from a Central Zone perspective, but I think from an overall provincial perspective, we did implement and do use a bed utilization management system. Part of the benefit of that system is it actually helps us to identify the barriers to discharge. Active discharge planning is happening and looking at what those barriers are and identifying solutions to actually help people discharge.

You are correct - hospitalists have been shown in the evidence to actually decrease length of stay and that's really because they are part of the team. They're there and they can work with the family and other members of the team to facilitate the appropriate discharge.

The other thing, and I just want to comment - yes, there are service-specific beds, but as a system on any given day, we do have bed-management rounds where we actually look at all the patients who are coming into our system and looking at how we use those beds most appropriately to meet the needs of the patients. Some patients require very specialized beds and they have to go where those staff have those skills. Other patients can be appropriately cared for in beds off-service. So as a system, we look at how we can meet the needs of the patient populations we serve globally.

MR. HOUSTON: So that bed utilization system is used in Central, but maybe not in other regions?

MS. SULLIVAN: No, it's used in all regions.

MR. HOUSTON: Would that suggest that there are decisions being made on bed utilization for hospitals in Pictou County, for example, from Halifax? Would that be somebody on the ground at the hospital who is looking at that?

MS. SULLIVAN: Every single former district, and now zones, had people responsible within their specific areas for bed utilization and flow.

MR. HOUSTON: So it's somebody in the zone as opposed to somebody on-site at the hospital?

MS. SULLIVAN: I believe Aberdeen had somebody on-site responsible for bed flow responsibilities.

MR. HOUSTON: I think you used the word "had" though.

MS. SULLIVAN: Because it had been Pictou, but within that specific facility, that hasn't changed. Prior to April 1st, they had somebody responsible for flow, and I believe all of our major facilities did; Janet can certainly confirm that they did have. It was an overall provincial project and part of the implementation required some utilization coordinators or flow coordinators to be part of that. Janet?

MS. KNOX: I can confirm that. The organization that I come from led that provincial project. It is the people in the facility using real-time data to help manage their beds on a daily basis. The advantage of this utilization project was that when we got in a crunch across the province, we actually could sit and see where all the beds were around the province. So it has been a very useful project. That's a very good example of where we are one month into the Nova Scotia Health Authority. We have not changed any of that work that we want to make sure . . .

MR. CHAIRMAN: Order. I'm sorry, we must move to the next round of questions with Mr. Wilson and the NDP.

HON. DAVID WILSON: Thank you, and welcome. Thank you for your first visit to the Public Accounts Committee, and I assume it won't be your last visit. Health and Wellness definitely comes before our committee quite often and I think it's because of the sheer importance of the department, so I welcome you and thank you for coming.

I think going second, you're led down sometimes by previous questions, so I'm going to jump into some of the areas which I thought I would get into a little later in my questioning. It was around the savings. I've been trying to get those figures from the minister for some time. You indicated a $5.5 million saving, and then that's off your budget now. But how can you really say there's a $5.5 million saving when we know that $4.8 million went out for severance? To me, the saving is now $700,000. Do you have a comment on the fact that it's $5.5 million supposed savings, but yet we know $4.8 million went out in severance alone?

MS. CARMELLE D'ENTREMONT: Just the severance costs are incurred in the year that it occurs, so severance costs were incurred last year. You're accurate, there was a cost last year of approximately $4.8 million to the health system.

The severance costs are a one-time cost. The savings costs are annual, so in this fiscal year, 2014-15, the elimination of those positions is that saving and that saving will be carried forward because those positions are no longer there in the years to come.

MR. DAVID WILSON: Thank you for that. So we really haven't saved $5.5 million yet. To be very clear, we're in the hole because of the amalgamation over the last two years. I know you mentioned that 70 people were given notice or, I would say, given their pink slips, fired maybe; 29 of them came back, so that leaves 41 individuals who no longer work in the system who received $4.8 million. If you just do the math, on average, that's $117,000 per employee that was asked to leave.

We're two years into this. There has been chaos - you might have a different opinion, but there has been chaos in the system. We haven't seen improvements in a lot of services. Is that worth what we've gone through over the last two years to pay out over $100,000 on average - $117,000 on average - just to reduce the administration by 41 people? I don't get it, but maybe a comment on that?

MS. KNOX: Thank you for that question. I would say that what is worth it to us and why we are sitting here as the Nova Scotia Health Authority willing to move forward is that this is an opportunity to really look at how we use the full resources of the Nova Scotia health system for the 940,000 people we serve. I come from 10 years of having been a CEO in a smaller district health authority. We were very focused on it being as efficient and effective as we can be, but as CEOs, we knew that we had reached the limit in terms of what we could do.

Our goal really needs to be to say we are using our resources here in Nova Scotia to change the health status for the future. I agree with you, it is a huge challenge; it is also a huge opportunity. That administrative issue was clearly, purely, that's nine-to-one done. The rest of our work now is how we make sure that we're using our resources in the most efficient way to change the outcomes for health.

I would say you're right. Whatever this is, 34 days - I say to my team - we were in 17 days - you can't change the world in a month, but we're reorganizing in a way that will help us look provincially and stay focused. In five, 10, and 15 years' time, we can say that we will have made - it will not just be a reorganization of the Nova Scotia health system; it has to be a reorganization with a purpose for a change in outcomes for the people.

MR. DAVID WILSON: I appreciate those comments. I recognize those future savings and I just wish the minister and the government would have been more clear and up front with Nova Scotians. There was supposed to be a $13 million saving, not $5 million. I know that's not your doing.

There would have been more costs to the amalgamation. I just look at your opening statements and I see the new emblem for the Nova Scotia Health Authority with a bit of a wave on it. You indicated 23,000 employees, many of them I would think would have

business cards, so there must have been additional costs. For example, was there a request to come up with a new logo - how much did that cost? I don't undermine the work, but there would have been a cost to that.

Could you give me a cost maybe of the new logo - was that something that cost taxpayers money, or did we do it within House?

MS. KNOX: Thank you for that. I could say we probably did very well. Yes, there definitely was a cost, it was around $10,000 to do that work, and the major part of the work would be to talk to Nova Scotians in communities, to talk to foundations and auxiliaries who work with organizations, to spend time with our staff and so there is a cost in terms of you have to have an organization that people are aligned with, there is a cost of doing that business, I absolutely agree. I think it's fundamentally important in terms of how we bring people together to support, and I can say that we probably have done things the most efficient way we possibly could. I feel very proud of that. We are a Nova Scotia challenge, made-in-Nova Scotia solutions by Nova Scotians, and we will continue to pay very much attention on how we use public money to make sure that the outcome is the right outcome for our people.

MR. DAVID WILSON: The reason why I go down this path is the fact that we heard, through a previous question, that the $5.5 million is gone; it's gone from your budget. I was under the assumption it was going toward front line and reinvesting in front line.

Are we ever going to see a total cost? It was pretty quick, finally to get the $4.8 million in severance, that's easy to figure out, but there is a greater cost to this and I haven't been able to get that answer from the minister, so I'll ask you, will you be able to tell Nova Scotians exactly what it cost to amalgamate the district health authorities? I don't want to argue about why we did it, but there was a cost - will Nova Scotians see the end cost of the amalgamation, and can you provide that to the committee?

MS. KNOX: I can speak to you about our approach in terms of how we will end up with a definite budget soon, and our strategy here is everything we do is mitigated by something else. So, if we have to develop a logo, there's $10,000 we have to find from somewhere else. So it will be hard to - what we will be able to say to you, what is the cost of running the Nova Scotia Health Authority, we will be able to say that to you. Our approach will be that we are learning what it costs to redevelop an organization with the proviso that there are no additional resources here. We will have the budget that's given to us that will be somewhat of an amalgamation of the nine previous.

MR. DAVID WILSON: Okay, I'm trying to figure out - I know in the old system there were business cases that needed to be approved by the district health authorities by the department. So, your budget is not approved yet from the minister - the minister hasn't signed off from the department and handed you what your operating budget will be for the next year?

MS. KNOX: We generally know, and we are working with the department on a couple of issues and we are expecting that within the couple of weeks we will have that finalized.

MR. DAVID WILSON: I know, legislatively, I think the districts had to have that approved, and I know that governments have been trying to play catch-up. You're saying that in the next couple of weeks you'll know that figure? Okay, thank you.

We talked about the 41 people who have left the system and most of them were VPs and CEOs but it's my understanding that there are a lot of directors now. Did we see an increase in directors, or did we go to those directors who were in place and indicate that this is your new role, we're going to transform what your responsibilities were with the new zones - is there an increase in directors here in the province?

MS. CARMELLE D'ENTREMONT: There were some new senior directors introduced to ensure some provincial coordination. In those cases the mandate of those program portfolios was to ensure that the cost of that role and the FTE would be managed within that portfolio, so that it would be a new FTE. In some cases the selected individuals who were successful in that posting, their positions are not being replaced, so it's not a new FTE - they might have been a director if they were successful in a senior director role, and that provides some opportunity then to look at shifting. So there were some senior director roles. That was largely introduced because again if you look across the province at the number of COs and VPs we had, and when you reduce that to a structure that is much smaller, we also need to have an effective way to manage the largest employer in the province, with 23,000 staff.

The number of direct reports, the manageable spans of controls for the executive directors and the VPs had to be taken into consideration. So some of that is really - it's not adding a layer, it's moving so that there's better alignment because you can't remove a layer of administration without redesigning or restructuring gradually through the organization.

MR. DAVID WILSON: So I would assume the responsibility may have increased. With that, would their salaries increase? Did they go into another level for collective agreement - well, they wouldn't be collective agreements, I guess they would be management - but salaries most likely would have gone up, if they are being asked to do more, is that correct?

MS. CARMELLE D'ENTREMONT: The senior director roles - we have a process that we use the Hay evaluation as the valuation to assess and we have an arrangement with the Health Association of Nova Scotia that they perform that function for us. So the positions would have been Hay evaluated for scope and complexity of work and then assigned to the pay bands.

The new senior director roles that we've introduced have been - they change in levels. They have not to date been higher than what would have been in some cases director position at central so they actually have not necessarily gone up.

MR. DAVID WILSON: How many new positions? I know you indicated there were a number of new positions created and then on top of that you talked about the pay bands. Can you indicate what those pay bands are?

MS. CARMELLE D'ENTREMONT: It depends on the senior director role. The highest is what we call pay band 18 and we have some that have been rated at pay band 16 and others at pay band 17.

MR. DAVID WILSON: And then the number of new directors? I know you said there were some new directors.

MS. CARMELLE D'ENTREMONT: I'm trying to think of the exact number, I don't know if it's 10-ish.

MR. DAVID WILSON: You can provide that to us later, if you want.

MS. CARMELLE D'ENTREMONT: I'm sorry I have to go and look at . . .

MR. DAVID WILSON: That's fine, you could provide that to the committee a little later.

So the pay band, they're non-unionized positions, I wonder if you could give us a quick definition. What does the pay band mean, dollar-wise? How much of a range difference between 16 and 18, if you could get that? If you don't have it in front of you . . .

MS. CARMELLE D'ENTREMONT: I don't, I can tell you that the pay band 18 would have a range that the maximum is approximately $140,000. In terms of the bands below that, that would vary. I can get that information; I don't know it by heart.

MR. DAVID WILSON: That's fine. My recollection - it seems like so long ago that I was over in the department - that's pretty comparable of what VP positions were allocated, about the $140,000, they went up. Anyway, we'll leave it at that. If you could provide us with more information on the exact scale, I'd appreciate that.

I'm going to turn now - because I could probably spend two hours on this stuff - but I appreciate the openness and the willingness to provide us with the information. I noticed in your opening comments, Ms. Knox, that you mentioned how competitive it is and the need to make sure that the recruitment retention and the high number of nursing grads out of the 2014 class were working full time; I think you said 92 per cent. To me that paints a picture that there's a need. How competitive is the environment today, just

nationally? I know the U.S. draws some and attracts - maybe North American. What is the environment like today for the recruitment or the attraction of these new graduates? Do we have to be competitive and are we making sure that they stay here in Nova Scotia?

MS. KNOX: The first thing I'd like to say is I want to ask my colleagues here to speak, Vickie and Mary Ellen. We need to be competitive, we need to make sure that we have the very best workplace and we can never take our eye off of that. It's very, very important because our people in Canada travel and move across the country quite readily, and so we do need to make sure that we're paying attention to a safe, productive workplace that encourages people to come and grow their careers. We're very committed to that. For more real information - my colleagues who do this on a regular basis every day. I'd like to ask Vickie perhaps to start.

MS. SULLIVAN: Nationally, I think there are some jurisdictions that actually aren't hiring right now. I understand Ontario is one and I believe Alberta has some freezes. Depending on what province you're in, I think some provinces are recruiting and some aren't.

In the Atlantic area, we do find that we get a number of applicants from Newfoundland and Labrador, New Brunswick, and P.E.I. We actively continue to recruit Nova Scotians, but also looking more broadly in the Atlantic region.

We do know, I think, from a recruitment perspective, if people have roots here, they tend to stay as long as we can provide them with permanent employment and a work environment that is exciting and rewarding to them. Mary Ellen?

MR. DAVID WILSON: I'm good with that. What I wanted to know is how - and that can change as a jurisdiction opens up their budget, stops the freezes that you see.

The reason I go there is that over the last month or so, we've heard repeatedly from the Premier that really, in his view, the wage packages for our health workers are extreme - they're too high. I remember the 1990s, when the environment was much different. Many of my friends, when I chose to go to paramedic school, went to nursing and left because of the competitive nature of the environment - because we were not competitive in our wage packages and benefits.

Do you feel that our wage packages for, I'll say, the 23,000 employees are too high and too rich, that we need to look at maybe scaling that back? What does that do to our ability to attract workers? Ms. Knox, do you have a comment on that?

MS. KNOX: We reach our wage package through a collective bargaining process and I will always honour that. It's very, very important to me. I think generally we want to make sure that we're in the range that is attractive and as an employer, that is our preparation in terms of monitoring that.

I think that as we rate all of our jobs and as we create contracts with our employees, we have to pay attention at all levels to what we can bear as a province. It's a process that we go through on a regular basis and there are different responses for different times.

MR. DAVID WILSON: So do you feel that the wages are too high for nurses in Nova Scotia? I don't know if you want to answer that. Are we at the top within Canada on wage packages for nurses on how much they make an hour and their benefits? That data is there - I just don't have it in front of me.

MS. KNOX: I can't really tell you where we are in the 10 provinces. I know that we stand very well in Atlantic Canada. Maybe Mary Ellen can offer to that. What I would say is this is a contract we have with our employees. I would not say it's the wrong contract. We signed it; we agreed to it.

MR. DAVID WILSON: I appreciate that. I wish we would get that kind of answer from our Premier because I think it does damage to it. I think I have only about 30 seconds left in my questioning, so I do appreciate that and I look forward to - if we can get that data just so that we can set the record straight, that we're competitive, but we need to be because we see what happened in the 1990s when we were not competitive when it comes to wage packages. We have a shortfall of nurses now and I'll get into my second round of questioning around direct questions about that.

MR. CHAIRMAN: We'll now move to the Liberal caucus and Mr. Rankin.

MR. IAIN RANKIN: Thank you for coming in. My question just gets right into the numbers again because I think there is some obscuring of the lines when we're talking about the savings incrementally year-over-year. I just want to make sure. Obviously when there is structural change in the year, they are going to incur some one-time costs. So just to make sure I have the number right, the $5.5 million, that is the true savings number but in the first year we spent roughly $4.8 million in severance and then another, probably - how much more did we spend on other one-time costs?

We probably took a loss somewhere, so how did the first year materialize? Did it materialize in any saving or was it roughly awash because of the severances?

MS. KNOX: I'll start and Carmelle d'Entremont can add to it. The severance costs are not in year one of the Nova Scotia Health Authority, they are in the last year of the nine district health authorities. So we are starting from square one, without carrying that challenge.

MR. RANKIN: I just want to get it on the record - so going forward now, including this year, there will be real savings from the reduction of administration. How much will those savings be?

MS. KNOX: It is $5.5 million. We will be not be spending that money . . .

MR. RANKIN: Okay, I just wanted to make sure that was on the record because they intimated that there would be no saving, so that's good to get it on the record.

Now that $5.5 million, would it be fair to say that that would on front line? I can't imagine it going anywhere else. We are talking about 0.1 per cent of the budget that would be swallowed up rather quickly in front-line services. Would that be fair to say that's where those savings went?

MS. KNOX: The savings means we are not costing Nova Scotia $5.5 million. That's gone, we can't spend that $5.5 million.

MR. RANKIN: Right. So because health care - I guess what I'm trying to get at is health care budgets go up, inevitably, so it's easy to see that $5.5 million going into that budget somewhere. Actually it's going to be a lot more, even with this year, the 1 per cent increase, it's a lot more than $5 million so I would surmise that $5 million is in front-line care now.

MS. KNOX: We would say there are other pressures in the system that we have to mitigate, so we will use that. Our goal will be not to disrupt the patient care, so that $5.5 million will be used to mitigate other pressures that we will see in the system, like the continued cost of utilities, those kinds of things.

MR. RANKIN: In terms of utilization of your staff resources, is there any movement to getting the LPNs more involved? I remember hearing about possibly signing off on patients, and you mentioned discharge, so allowing patients to get out instead of waiting for a doctor to give that official sign-off or any other elements to it that you can share with the committee?

MS. KNOX: Thank you. I would ask Mary Ellen Gurhnam, our chief nursing person in Central Zone, to talk to that.

MS. MARY ELLEN GURHNAM: With respect to LPNs, there has been ongoing provincial work over the last number of years and very specific focus work within the central zone to optimize the role and scope of practice of registered nurses, licensed practical nurses, in effect the whole inter-professional team.

We are just on the cusp of implementing two initiatives that have been enabled by a change in regulation to allow nurse practitioners to discharge, and we will be doing the prototype of that at the Dartmouth General Hospital starting mid-June, July.

Another initiative will allow registered nurses to assess, treat, and release patients from emergency centres and CECs. There is a pilot of that as part of the staggered implementation process that will happen in Yarmouth.

MR. RANKIN: Okay, that's great to hear. I'm just wondering, in terms of the emergency health services, and paramedics, are they going to be involved going forward in the community-based care that we're trying to get to? Are we going to be able to use them, utilize their services when there are not emergency calls, to equip them with more - maybe it is equipment or actually anything more that will help utilization from the emergency services part?

MS. GURNHAM: We are continuing with the model of emergency care that has been established around the community emergency centres and continuing with that. We are also looking at, in our emergency departments, how we employ paramedics and support their appropriate role within the context of an emergency department.

Most recently we have employed paramedics in the Hants Community Hospital emergency department, which has not been the case before. The system will continue to evolve and we will continue to look for ways to optimize all health care professionals.

MR. RANKIN: That's great to hear. Just one more question along the same theme is pharmacists - Nova Scotia, from what I was told, is one of the best and Saskatchewan is the other one that's good at utilizing them for more services. Is there any opportunity to expand on the delivery scope to get better access for people and simultaneously keep people out of the emergency room?

MS. GURHNAM: Again, in terms of optimizing the role of the pharmacists in Central Zone we have just passed some policy direction that will enable pharmacists to prescribe within the context of the Interprofessional Collaborative Practice team. Again, we are continuing to look at how we can evolve the role of our clinical pharmacists to support patient care and the team.

MR. RANKIN: Thanks very much; very impressive.

MR. CHAIRMAN: Mr. Stroink.

MR. JOACHIM STROINK: We hear a lot about rural parts of Nova Scotia not having the health care they need, and I had great privilege to visit Caledonia where they seem to embrace that situation far greater than a lot of other places, where they fundraise as a community and pretty much everybody in the community gave $100 to build their own health centre, and they were one of the very first people to hire a nurse practitioner. That's kind of what I want to touch on a bit is the NPs and their contribution to rural parts of Nova Scotia and how do we support that initiative. I throw that to you for a moment to answer that.

MS. KNOX: I'll begin, and Mary Ellen may be able to help further with this.

As I said earlier our goal as we step forward is that community-based services must be the foundation of the support of the health system for Nova Scotians, so looking at what

are the community needs and engaging the community in that conversation. That community that you're talking about is a perfect example, people understand what their needs are and we need to spend time with them to talk about what those are and then plan together a resource.

We will step out; there has been work done already, provincially, around primary health care with the framework for primary health care for Nova Scotia, that all of the previous nine district health authorities participated with the Department of Health and Wellness to get to that point. That's a wonderful starting point for us to look at what are the needs across the province.

The nurse practitioners are one of the disciplines that are very important to that and so what we believe is that every community may have some different kinds of unique needs, that the team may be somewhat different, but for sure the nurses practitioners play an integral role in that work in local communities.

I don't know, Mary Ellen, if there was anything that you would like to add to that?

MR. STROINK: How many NPs are there in Nova Scotia?

MS. GURHNAM: About 140.

MR. STROINK: About 140.

MS. GURHNAM: I believe so.

MR. STROINK: Primarily where are they, in Halifax or are they in rural parts?

MS. GURHNAM: They're spread across the province; we do employ about 50 nurse practitioners in Central Zone.

MR. STROINK: From there I've heard, in the United States they do hire DNPs, doctor/nurse practitioners. I don't know if you've heard of that term - that's just one level up from a NP, in between the two.

MS. GURHNAM: A doctorate is not required for licensure in Canada; that doesn't mean we that don't have nurse practitioners who are not doctorate prepared.

MR. STROINK: Another thing, too, is you look at we want more immigrants to come in and the skill sets in European hospitals are sometimes far greater than Canadian standards - how are we utilizing those immigrants in our health care system to ensure that their skills are an added value to our hospitals verses, oh, sorry, you're not able to practise?

MS. GURHNAM: I can tell you that the Registered Nurse Professional Development Centre, which is a provincial resource for post-entry level in education in

nursing, has a program for internationally educated nurses, and a Competence Assessment Centre in an environment that supports them to be successful in getting their licence. There is also a program that they offer to all internationally educated health professionals which is an introduction to the Canadian health care system. So, again, for those professionals who are coming to our province, who are educated as health professionals in other jurisdictions, we have a system in the development centre to support their entry into the Canadian health care system, one that has actually been emulated and considered a best practice across the country.

MR. STROINK: That's also for doctors too?

MS. GURHNAM: Yes, the introduction to the Canadian health system is for physicians as well.

MR. STROINK: How many immigrants go through that per year - do you have any sense?

MS. GURHNAM: I don't have those numbers with me, so I can't answer that accurately.

MR. STROINK: Would you be able to provide those numbers?

MS. GURHNAM: Yes, I would.

MR. STROINK: Great, thank you.

MS. CARMELLE D'ENTREMONT: I was just going to add that with a province our size there are benefits and some of that is collaboration amongst partners. There has been a model in place called multi-stakeholder tables. It was an issue led by the former MISA, the immigrant settlement agency, where they have brought together, to address issues related to trying to remove barriers for internationally educated health professions, various tables that would bring the regulator who is a critical player because they regulate the profession, the employers, the settlement agencies together to discuss the needs. There is an internationally educated nursing table, there's a table for internationally educated medical grads, there's one for MLAs and there are also some for non-health professionals – engineering and so on.

That is really an effort initially led by the community and the settlement agencies to say let's bring the key players that each have a role: the employer as the person who hires; the regulator as the individual with the organization that sets the licensing requirement; and then the agencies that support the integration of the foreign nationals or the immigrants who arrive. I think that's a very positive model that we have in the province that is somewhat envied by other jurisdictions.

MR. CHAIRMAN: We will move to Ms. Miller.

MS. MARGARET MILLER: Thank you for all the information, it's really wonderful to hear today.

I have a few questions about nursing and nursing numbers. We keep hearing in the House, our Opposition members telling us the people in the gallery are retiring; they're leaving; there's a mass exodus; we have a huge nursing shortage; and we are in dire straits and Nova Scotians will suffer for that.

Can you tell me - is there really a nurse migration? Are nurses leaving the province, are they coming in? Can you give me some idea of numbers? - that kind of thing. And the graduates - I have a good friend who just graduated from nursing school this year and she's really excited about getting into nursing. Four years after being out of school for ten years, I'm really proud of her for actually going back; it was a huge accomplishment. I would like to know that she is going to have a job in Nova Scotia, and also other nurses in the program will as well.

MS. KNOX: Thank you for that question. We're very interested in that ourselves and have done a lot of work to understand it. I think all of my colleagues will have something to say to this, and we'll start with Carmelle d'Entremont.

MS. CARMELLE D'ENTREMONT: When we talk health workforce planning it's never black and white; it's a complex world. We would say in Nova Scotia we do not have system-wide nursing shortages. That doesn't mean that we do not have challenges in recruiting to certain hard-to-fill specialty areas which we are experiencing and, in some cases, hard-to-fill communities or hard-to-recruit-to communities.

There has been a lot of work. This province has been fortunate that there has been a provincial nursing table that has brought together government, educators, regulators, and employers, to look at the nursing situation for over 15 years and to monitor it. The age profile is a challenge. We have known it has been coming. We are beginning to see enhanced retirements, not massive numbers but we are seeing some increase in retirements. To use the Central Zone as an example, in the last two years we've had some increased nursing retirements. The age profile would demonstrate that that's not a surprise, but generally speaking when we look at our overall nursing numbers in the province, the inflows and the outflows have been kind of married up.

So the number of people leaving the province, either because of retirement or voluntary attrition and those entering the province as new registrants has kind of balanced out and actually increased in terms of - we have more nurses now than we did certainly 10 years ago.

That being said, there are some challenges caused by our demographics. The new challenges that we face, of course, are that we do know that, as Janet identified, our older age cohort is growing older. They are now approaching retirement age, so more of them will be leaving.

We've actually done a great job with our new grads. There was foresight in terms of additional nursing seats that were increased in 2003 and 2008. They've just been entering the marketplace in the last few years - the increase from 2008 in our RN nursing numbers. We have more new grads; that is appearing in our stats.

The other success story, I think, is that we have for a number of years - not just recently - been successful in retaining our new grads. So as was indicated, our pattern of how many new grads who, a year after graduation, are still registered in the province and working is about 90 per cent. That is a very good number.

Our ability to offer permanent employment has been critical. There's some research that indicates that the biggest indicator of whether or not we retain our new grads is whether or not they get permanent employment. When we've not done so in the past, we see that pattern replicate itself in the numbers because they will look elsewhere. The fact that we've been successful in giving permanent employment means that those younger nurses - that number is increasing.

The challenge that it presents, however, is what Janet identified - the fact that we have, caused by our demographics, an experience gap. As our older nurses are leaving, we have a significant portion - 20 per cent of our workforce has less than five years of experience. We need new strategies because we cannot assume that the new grads who are increasing in numbers can automatically walk into those positions where there are specialty requirements. Maybe I'll stop and perhaps ask Ms. Gurnham.

MR. CHAIRMAN: Ms. Gurnham.

MS. GURNHAM: We have, over the last number of years, hired a significant number of new graduates into the Central Zone and have done a lot of work to develop a transition-to-practice model that supports their entry into practice and their on-boarding. We put some specific, focused work into developing programs to introduce new graduates into the ORs, critical care units, and our emergency departments and have a socialization and on-boarding program that involves significant clinical mentorship for those new graduates, streaming them into the Registered Nurse Professional Development program that offers certificate specialty training in critical care emergency and perioperative nursing.

Following graduation from that program, again it provides them a period of time of clinical mentorship and increasing levels of accountability based on their individual competence. We continue to evolve those programs and improve them based on evaluations every year.

We're also working with universities, Dalhousie in particular, to introduce more specialty options into the undergraduate curriculum. We have also looked at putting in an additional clinical resource role at the point of care to support practice development where

we have areas where - we've determined that if 40 per cent of the staff have less than two years' experience, we generally need to put an additional clinical resource role in there.

MS. MILLER: It sounds wonderful. It sounds like it's not a doom-and-gloom story, that it's very positive. It sounds like the ages of our nurses are actually decreasing or we're getting a lot more younger nurses who are going to be in for the long haul and who are going to be working in Nova Scotia. Am I getting the right concept there?

MR. CHAIRMAN: Ms. d'Entremont with just about 15 seconds.

MS. CARMELLE D'ENTREMONT: We are seeing growth in the older age category. We're seeing growth in the younger age category. It's the middle cohort that has gotten smaller.

MR. CHAIRMAN: Thank you. Order. We'll now move to Mr. Houston.

MR. HOUSTON: Thank you Mr. Chairman. I want to go back, I think I have 14 minutes so in that time I want to talk about the budget and I want to talk about the nursing situation too. In terms of the budget, I did have a photocopy of the Estimates Book, which is the full budget for the province and in the Department of Health and Wellness they have a $4 billion budget and there's a line item there for the Nova Scotia Health Authority that's roughly $1.5 billion. I think that's your line item, right?

Okay, so that's the line item that I wanted to talk about because last year's estimate number was $1,511,782,000 - I don't know, what is that number? It's gone up and that was the estimate and it has gone up now. The column that called the forecasts, that's the actual number, so they had an estimated last year and then their actual was more than that. It's up to $1.529 billion. Now the estimate for this year, which is this year's budget, is down below that actual and it's down by $10 million. I just wanted to come back to that because you did reference that $5.5 million in savings but the budget is actually down by $10 million as compared to what it actually cost to run last year. I wonder if you could just speak to that for a second?

MS. KNOX: That would indicate to us that we have a challenge that needs to be mitigated. When you look at those numbers, so that's the work that we do with the department in terms of planning how we're going to do that and we're in that process now. You're right, that says to me that we are presented with a challenge that we have to mitigate.

MR. HOUSTON: So, the $5.5 million in savings for the consolidation - and you did reference that was gone now, that's just money that won't be spent - you also have to go and find more savings on top of that. That is a challenge, I would say, in health care where costs with our demographics and just inflation and everything else, something's got to give to save $10 million this year, I would say.

MS. KNOX: Yes, you're absolutely correct - $10 million on a budget of $1.5 billion. That is the world that we live in and we have been in that world for six or seven years. Every year we are faced with not enough resources to run as we had the previous year and so that is our strategy around efficiency and really looking at how we make the most of our resources. It is our challenge. It is a challenging time, when you're starting a new organization, to have that challenge before you as well.

I would just say, in my entire career as an administrator that has been our challenge because it's an ever-growing cost in terms of our cost for salaries, the cost for utilities, so we are always challenged with how we meet that budget.

MR. HOUSTON: With those cost constraints in mind, I want to talk about the nursing situation now. Do you have a number for the average age that a nurse in Nova Scotia retires? Is that a statistic that you would have?

MS. KNOX: I'm going to ask Mary Ellen Gurhnam to answer.

MS. GURHNAM: I can't give it to you for the province but in looking at our figures for the Central Zone, it has been between 58 and 60.

MR. HOUSTON: I think we heard in the opening comments that 46 per cent of the province's nurses are over the age of 50. That would imply to me that in the next eight to 10 years, 46 per cent of the nursing population we have now will be ready for retirement. That's not a long time. To me that does indicate that there is a crisis in how those will be filled over that time. Would you agree that's reaching crisis levels over the next couple of years?

MS. KNOX: What it does say to me is that we need to have very focused strategies year over year with a long-term plan. I will just say to you, this is my fourth decade. I am a nurse. We were talking about that as we got together. We came together to Nova Scotia in the 70s and every decade has created very different realities. At one time in my career as a director in a certain institution in this province, I can remember when we had 52 per cent of our nursing staff on most of our inpatient units with less than two years of experience; that would have been in the 1990s. When I came here in the 1970s, I was the only one in my class who got a job; two years later, there still were the rest of my classmates who did not have employment.

We are staring this directly and know that we have to have very distinct strategies. The number one has to be that people want to come and work with us - we have a place where they want to be. Our very best thing is to have as many people applying for jobs as we can. Our second strategy, among others, has to be that we are working with really understanding how many we need to graduate in this province in what process and times over the years. That's the work that Mary Ellen and Carmelle referred to in working with our universities and colleges. It is a multi-pronged strategy.

The other piece that we also have to remind ourselves is that as we plan health services, nurses are one very important part of the delivery of services, but remember, I said earlier, we have 200 different types of professionals working with us. We need to maximize the scope of the nurse; we need to maximize the scope of every single person. I like the other questions that were being asked about pharmacists and others because that's how we're going to get to the future. We really need to be open to looking at what all the possibilities are for how we engage our entire 23,000 people.

I think we're on a good road to that. That means we need to work with our professional colleges, with our unions, and with our staff to really maximize who they are and what they can bring every single day to that. It's very important work and multifaceted.

MR. HOUSTON: Yes, for sure. You did reference earlier about the importance of retention. In thinking of retention, I'm just wondering how you would describe the morale amongst (a) the nurses and (b) the whole group.

MS. KNOX: I will start, and I invite my colleagues to talk about that. We are in a massive change on many fronts, and so this is a very challenging time for our employees. We understand that. I say we understand that because if you've been where we have lived in our career, we have been through this many times, so we're very cognizant of the massive change and what that does to morale.

Just the fact that we have changed who the leaders are in an organization. I did do a tour prior to stepping into to April 1st. I was out around in the nine previous organizations meeting as many people in our staff as I possibly could. Since we began April 1st, our vice-presidents then picked that up with the executive directors. But I can tell you that we understand that people are - it's a changing time, so we're paying attention to it.

You know that there are many different things that can affect morale, so I guess what I would say to that it is something that I always want to say that we are paying attention to, that we never take our eye off, because we need people to understand that we want to know what is important to them in our workplace and we need to be connected with them. We've done a lot of different things in terms of - besides being physically present, I weekly have a connection over the Internet . . .

MR. HOUSTON: So would you say that morale is high or low?

MS. KNOX: I would say that in pockets we have real worry about change, and in pockets we have real optimism about change. So it's really hard to say, but it is something that we will pay attention to.

MR. HOUSTON: Speaking about the overtime of nurses, I think there was a comment made that said that better collaboration can reduce overtime. I was thinking of that comment in the context of the discussion about the distribution of resources. I just wondered if there is any - I don't want to read too much into that better collaboration of

resources, but does that mean that there would be a thought process of moving nurses around? Will you work at this hospital this shift and work at a different hospital the next shift? Is that something that is happening or is it something that you are contemplating as part of the better collaboration of resources?

MS. KNOX: I'll start, and I think Carmelle will want to add to that from a perspective of how we work with our people. What I meant by that is as we look at our service delivery across the province, there may be places that are underutilized that we could be doing more work while we're doing work in another place with overtime. It is having . . .

MR. HOUSTON: So it would be the patients that would move, not the staff, in that example?

MS. KNOX: Exactly. We have some wonderful examples of that already where the former Capital Health did a project with the former Cumberland Health around surgery for individuals who had hernias. People came from around the province to Amherst, very well appreciating the service that they received there. So it is an example of - where do we have the resource to do the work?

MR. HOUSTON: Okay, thank you. In terms of out-of-province nurses, I hear a lot of talk about nurses coming in to work here, described as paid travel to come in here, paid living per diems while they are here, plus paid a wage. Is that happening, and how many out-of-province nurses would be working right now in the system?

MS. KNOX: I'll as Vickie Sullivan to respond to that.

MS. SULLIVAN: Yes, it is happening and it is to address a very specific issue. We have some very hard-to-recruit positions related to our intensive care areas where, in spite of aggressive recruitment, we were unable to attract anybody. We've maxed-out our resources internally and externally within Nova Scotia. We've done national searches and we're not able to attract people. So we really had to look at how we balance that because obviously our intensive care areas are important areas to keep open and we need a certain level of staffing.

There was a process that was managed through our internal services where they did go out to procurement. There is a contract that was signed, and I believe it's about 15 travel nurses who will be engaged over about the next six months who will come here specifically to work in specific ICUs for us to able to maintain service.

In the meantime, we have 29 people who are completing the critical care course. They complete at the end of May. Twelve of those are new graduates, and I think these are settings that we have typically not used new graduates. They need a different level of support to come up to speed versus those people who have experience.

MR. HOUSTON: Sorry, so the 15 - that would be 15 for six months, is that in the Central? Do you have a similar number for the province?

MS. SULLIVAN: Yes, it is for the Central Zone. I can't speak to the rest of the province. My understanding is that was specific to the Central Zone and that had predated the merger when the issues had come forward and we needed to look at a strategy. My understanding, though, is that a contract could potentially be open for other zones to access, if required for specific services.

MR. CHAIRMAN: Order. We'll now move to the NDP caucus and Mr. Wilson.

MR. DAVID WILSON: Thank you, Mr. Chairman. I am interested in this, but I will continue on with mine and hopefully get back to the travel nurses, because I'm definitely interested in your last comment that the likelihood of opening this up is possible for travel nurses to go in other parts of the province, other than - is it called the Central Zone? I'm still learning. The Central Zone - it sounds different and it's going to take some time, I guess, to understand that.

I just want to go quickly. You had indicated $5.5 million in savings with the reduction of the administration, but we heard that there were 10-ish or so increased number of senior directors who are in place, which is interesting since we had nine-ish - I guess you could count 10 districts before, but nine districts. We have 10 new, maybe more than 10. The savings, the $5.5 million savings, did you calculate the increase in wages for the new directors in that or is that a separate budget line item? Hopefully you understand my question.

MS. KNOX: I'll start, and Carmelle may want to add to it. The senior director position is a position that would be an individual who would lead the provincial planning or the provincial management of a particular service. As we came April 1st we would have nine directors in the province in that service, generally.

Our direction, in terms of how we proceed with having someone take the lead for bringing the services together, have common standards, make sure we understand how that is delivered in the best and most efficient way across the province, is that when we hire a person to lead that service, that is one less position to start in the service. If there happened to be an increase in a salary that has to be found within that service.

Generally speaking, over time we will not continue to have nine directors in a service. That will happen over time but every decision we make has to have no net new costs. There has to be a mitigating strategy before we step out and make that decision. That's how we will manage forward.

MR. DAVID WILSON: So meaning something needs to be cut. I would assume these senior directors, if they're going to lead the initiative, are acting as CEOs. We just got rid of nine district health authorities, CEOs, VPs, yet we hired lead directors -

interesting. You mentioned that there may not be nine in the future? So you're going to get rid of some of the directors in the future at a certain point - is that my understanding?

MS. KNOX: We have one organization and previously we had nine. Each organization ran their services with their management team. We will have a streamlined management team, yes, in the Nova Scotia Health Authority. It is one organization and that is true.

MR. DAVID WILSON: So that nine will go down eventually. Will there be severance paid to those directors or was there something in their contract that said you're going to be asked to take on this lead, to act as a CEO but you're not a CEO, did they all sign new contracts and is there a provision for severance in that contract?

MS. KNOX: We always will honour the terms and conditions of employment for any of our employees. If we have eliminated a position, there are rules on how we live that out and what the rights are of the individual.

They are not CEOs; they are leaders of a department within the Nova Scotia Health Authority, a senior director of a department. In the previous organization there would have been directors of those departments, absolutely. Again, whenever we make decisions like this, the total cost of the decision has to be mitigated out and so we really are being very careful; we can't move so quickly that we can't manage that. We're very focused in the work that we do and learn from every decision we make how we make this the best use of resources in Nova Scotia.

MR. DAVID WILSON: I understand and respect that. What that tells me is down the road we'll see another figure of potentially severance because if you're going to respect the positions they have - so that $4.8 million was really just for the initial VPs and CEOs so I guess we'll have to wait and see.

As you answer I'm trying to write down and get back to some of the questions. I know you mentioned $10,000 for the new logo, which doesn't seem a lot in the big picture with a $4.1 billion budget overall, and your budget was $1.5 billion. Interesting, we're seeing cuts because you need to mitigate. You just mentioned you mitigate as you reduce and one of the mitigations we've seen so far from the government is $11,000 cut to the Eating Disorders Nova Scotia. A new website - cut $11,000 from Eating Disorders Nova Scotia. Can you give me the cost of the new website? Was there a cost for the new website? I know some of these decisions aren't made at your level, but I'm frustrated a bit - so is there a cost for the new website?

MS. KNOX: You're talking about the Nova Scotia Health Authority website?

MR. DAVID WILSON: Yes.

MS. KNOX: Thank you. We did that in-house.

MR. DAVID WILSON: Okay. Thank you. So I'm going to go towards what my colleague mentioned around the forecast. We've seen a bump from the estimates, $1.511 billion to $1.529 billion. There was an increase and now there's a drop of about $10 million, which you'll need to mitigate and try to figure out and work hard to try to come within that budget. The $1.529 billion, I mean that's the forecast for the year, and we know that there's an actual budget, an actual cost. We're about a month after the year-end, are you able to provide us with an indication if that $1.529 billion is going to be more, or potentially less, or do I have to wait for the minister to advise Nova Scotia what the actual budget was - are you able to provide us that number now?

MS. KNOX: No, I'm looking forward to the number as well. As you know the process, the books are not completely closed yet, and so we really by the end of June will have the audited financial statements. That's a real opportunity. I'm very interested in that number too.

MR. DAVID WILSON: In that actual budget, when we get that number I know that through estimates the district health authorities, many of them were over budget, does that $1.529 billion represent the over-budget of the DHAs or is that something that will be absorbed through the department's budget, or will the new authority have to absorb that budget and that will reflect in June when we see the actual budget cost of last year?

MS. KNOX: We will know those final decisions in a couple of weeks when we finalize our discussions and . . .

MR. DAVID WILSON: So that decision hasn't been made yet on where that would fall - I mean there is a definite cost there.

Knowing the procedures, and you have mentioned a number of times the challenges that face you in the year ahead with the reduction of, so far $10 million, but it could be more, we'll wait for June. I know the process is to present the minister and the Department of Health and Wellness with a list of mitigations - have you provided that list to the minister or are you still working on that list?

MS. KNOX: Those are some of the issues that we are still working on.

MR. DAVID WILSON: And for those who might not completely understand, that means cuts and reduction in services. Are you able, at this time, to give us any indication of what you are looking at and in what areas you will have to look at to reduce services - either eliminate programs or just reduce their budgets? Are you able, at this time, to give us any indication on what you are preparing to give to the minister to see if they approve it?

MS. KNOX: What I will say to that, because I know you do understand that process very well, it's a challenging process and, until it's finalized, it's not finalized. I can say to you that as we step out with one organization as an amalgamation of nine, one of our very,

very big issues that we think will be of benefit, and we have begun already, is really looking at how our efficiency of every single line of activity at work that we do. The other thing I would like to say to this committee is that one of the things that we're learning from the nine previous organizations, they are wonderful examples of leading practices. In all those organizations we now will be able to move across the Nova Scotia Health Authority without trying to reinvent them nine times. The efficiency part of being one, we will maximize that beginning right now.

MR. DAVID WILSON: I understand the efficiency component of it and the administration component of it, but that is such a small portion. Even though it has a lot of attention there's not a lot of savings once this is finished when you look at a $4.1 billion-or- plus budget. Are you confident that you will be able to maintain services or will we see the need for reductions in services - are you able to say that today, Ms. Knox?

MS. KNOX: Our goal is to maintain the services that are needed for Nova Scotians. What I would say is we may find that we can deliver better service in different ways and still meet the needs of Nova Scotians. That's my experience in my life as a CEO. That's the approach we need to take. Our focus needs to be, what do people need from their local community to be able to be safe and healthy? That always has to be our call.

MR. DAVID WILSON: Does this new plan - and we've heard hints of it - is it going to require Nova Scotians to move around the province to seek the treatment? We've heard it from the minister, we've heard it from the Premier, and I think I heard it from you, so is that part of the plan - to require Nova Scotians to maybe move to different zones, to travel to seek the treatment they need? Is that part of the plan?

MS. KNOX: The plan is not complete yet, so we're beginning to look at how we provide services to support Nova Scotians. What we do know, though, is that the majority of care that is needed by people in general, and we believe the people of Nova Scotia, is what is delivered by support from a primary health care team in their local community.

We really need to make that our strength and our access there to be very, very clear. Every Nova Scotian needs access to that kind of care, so that means it's in local communities and they're not travelling a great distance. That's where we'll begin.

MR. DAVID WILSON: All right, thank you. I have to say that that's the impression our caucus is getting, that that's going to be a requirement. I hope, if that is the direction, that the government and yourself look at some kind of program that helps with travel costs for our patients because that is a barrier.

Quickly - I know I only have a few minutes - were 500-plus surgeries cancelled, I think, now? How in the world, with a frozen budget, reduction in your budget, are we ever going to make up 500 surgeries in the next year? I don't know how you're going to do it. Could you enlighten us on the plan to reschedule 500-plus surgeries?

MS. KNOX: I'd like Ms. Sullivan to talk to you.

MR. CHAIRMAN: Ms. Sullivan, you have just about 25 seconds.

MS. SULLIVAN: There is planning underway and we're looking at the types of surgeries that actually have been cancelled and looking at our capacity across the Nova Scotia Health Authority in terms of looking at where there's unused capacity that we may be able to use so we can maximize the use of that and hopefully address the surgeries that were cancelled. Obviously, that has affected many of our patients and their families and we're actively looking at how we can address that now.

MR. CHAIRMAN: Order. Thank you. We'll now move back to the Liberal caucus with Ms. Lohnes-Croft.

MS. SUZANNE LOHNES-CROFT: Were you finished with your comments on that? Okay, thank you; I'd have let you continue if you weren't.

I just want to mention nurse practitioners because I see them as the saviours of the health care system right now, especially in rural Nova Scotia. I myself use a nurse practitioner. I haven't seen my own GP since I couldn't tell you when, so I've been getting my health services between my pharmacist and my nurse practitioner and I'm very happy. I see them playing a larger role, especially - and my questions next week, I think, will be towards home care and what their role will be with home care.

How many are being graduated each year here in Nova Scotia?

MS. CARMELLE D'ENTREMONT: The provider of that program, which is a master's-prepared nursing program, is Dalhousie. It's approximately 15 intake per year and it's a two-year master's.

MS. LOHNES-CROFT: Is there a plan going forward to graduate more nurse practitioners here in Nova Scotia?

MS. CARMELLE D'ENTREMONT: We've had conversations with the Department of Health and Wellness on the supply and management issue. I think at this time, the number of NPs being graduated is sufficient for the number of positions we have for them in the system. If there was a radical change in terms of an increase in number of FTEs that the employers were providing them, we may need to adjust, but at this time it has been fairly well balanced. There are also some of our nurses who are taking courses possibly outside of the province also. I don't know. Mary Ellen?

MS. GURHNAM: We do a lot of clinical placements for nurse practitioners in Athabasca program and they graduate about 40 a year. At any one time we have at least between eight and 10 looking for clinical practicums in Nova Scotia.

MS. LOHNES-CROFT: Well I can see them filling a huge gap, especially rural Nova Scotia. I think we have to change our way, as the public, of thinking of the scope of their practice. I must say I've been pleased with my experiences.

I'd like to move on to the role of the community health boards now, and that was a great concern when we went into downsizing the DHAs. Have their roles changed and if they have, how have they changed?

MS. KNOX: There are 37 community health boards; that was the number that was supporting and working with the previous nine district health authorities. Their role has been strengthened, we would say, and really in the area of connecting Nova Scotia Health Authority with the community around the identification of health needs in the community. Really some great work, I think, as they go forward on that education about health, health promotion, and how we as communities need to focus on the health of our citizens.

We've begun this work already with the community health boards in terms of how do we support them better, to really have the resource so they can do the important work. In the legislation - and we're very pleased with that - it does confirm their role. It also confirms our responsibility to have them part of our community engagement, as the Nova Scotia Health Authority with the citizens and the communities of Nova Scotia, and also we will demonstrate how we use the information they provide to us, and new this time is that the IWK, who is our partner in care, we are working very well together, will also be able to use that information.

MS. LOHNES-CROFT: So there will be a greater role in communicating, they will be ears to the ground in our local communities, because we've lost that now with the one authority for all of Nova Scotia. There will be a definite process that they will be able to communicate what is needed in their local hospitals and areas.

MS. KNOX: The focus is really about what is needed in the local community. We want to broaden it out beyond hospital care, really what do the people need in the local community in terms of supporting health, and I would say that we would see them as great facilitators in terms of changing that conversation about health in local communities and really keeping alive and strong our understanding of the need to change to make sure that change impacts health and makes a difference for our health.

We are working with them to make sure that their local input is very important, at local agency level, but also at the zonal level because we really have common interest at the four zones and so we will have a process for them to come together at the zonal level, also to talk about what we're learning, and then at the provincial level what are the right connects to the provincial organization to make sure we truly do understand. You're quite correct, this is a very important group that will help us really be connected right to the front line where people live.

MS. LOHNES-CROFT: I'll move on to the health foundations, because I get a lot of questions about how their roles will change. Many are concerned that if they have a local community hospital - and I'll take Fishermen's Memorial for example. It was a hospital built by the community for the community. They put their heart and soul into fundraising for that hospital. They are very worried that their fundraising efforts will go elsewhere. What can I say to them to assure these volunteers, who give their heart and soul to the health foundation, that their money is going where they want it to go?

MS. KNOX: Thank for that question, these are very important partners, foundations and auxiliaries of our local facilities all around our province. Carmelle will be the executive lead to make sure that at our executive table, we are paying attention to how we support foundations and auxiliaries. She and I have already met with the provincial organization that the majority of them are there and we are taking our time in our tour around the province to make sure we connect with these very important volunteers.

Thousands and thousands of volunteers are connected to foundations and auxiliaries. We have said to them, we need to continue to support you to be that great resource in the community around your local facility. We are 100 per cent supportive of that. We also have begun very initially, but we were very pleased with the conversation that we had in terms of how we change the conversation about health and what health needs are and what it means in Nova Scotia. These are also very important volunteers who are connected in their communities and can help us with that as well.

We believe we've had a very important beginning with them as the Nova Scotia Health Authority, but you can say to them they are very, very much supported by the Nova Scotia Health Authority and are very much seen as a wonderful community partner.

MS. LOHNES-CROFT: Great, thank you. I will hand it over to my colleague.

MR. CHAIRMAN: Mr. Farrell.

MR. TERRY FARRELL: I do want to ask about home care. Will the Nova Scotia Health Authority continue to be the organization that administers the contracts for home nursing care and home support work?

MS. KNOX: Yes. We will.

MR. FARRELL: Okay. So I understand that now there's a process going on to create a request for proposals to explore the possibilities for that contract. Could you describe that process for me a little bit and the timelines that are underway there?

MS. KNOX: That process is one that is led by the Department of Health and Wellness, and so it is their process. As you know, they are the funders. Our role with the agencies is through a contract accountability agreement for the service provision and that's

how we work with them. We are just getting up to speed with that process with the department now.

MR. FARRELL: Thank you. I'm hearing a lot of concern in my community primarily from the people who provide those services now that if the intent is to make the service more economical, then things are going to have to be tightened up and the service itself may suffer as a result of that. There may be more pressures put on the workers who are providing the service, they may not have the time to work with their clients and do the things that they do now, and it's not going to result in an improvement - it will result in a decreased quality of service. Could I get your thoughts and comments on that?

MS. KNOX: What I would say to that is our interest in this process is to make sure that we have the right services available to our patients. That would be - as we begin the conversations with the Department of Health and Wellness that is responsible for this RFP, we will have those kinds of conversations about what we need through an RFP to make sure that we are able to provide our services. We have those interests in focus.

MR. FARRELL: I guess the other major concern is with respect to staffing and the security, if you will, of the people who are performing those jobs now and performing those functions now. From my point of view, I look at my understanding of the job situation and I think we desperately need those people. We're not going to find other people to come in and do those jobs, whether it is at the same wage or a lower wage. We have a highly efficient and effective workforce there that is in our interest to maintain. Do you agree with that or do you have any comments on that?

MS. KNOX: What I would say is those would be the conversations we would be having. Our interest is to make sure of a continued service.

MR. FARRELL: I did have one other question about the bursary programs that existed in the health authorities that were designed to - I think the money for those was collected through the health care foundations, but in the case of Cumberland at least, the local health authority would contract with the students and provide them with employment when they came back. In our area, it was a very effective program. I'm just wondering if the Nova Scotia Health Authority has a plan to continue to work with the local foundations to make that work and to bring students from our communities back to work in those communities.

MS. CARMELLE D'ENTREMONT: I think the practice varied across the province. In some cases, the health authorities themselves would have had return of service arrangements, and in other cases they may have been funded by a local foundation. As Janet has said, this is early days; part of what we'd like to do is look at the picture across the province in terms of what best practices are there. There is no immediate intention at all to take away a partnership that's in place. Whether or not we'd replicate it everywhere, I guess it would require some further assessment, and each individual foundation also identifies their priorities so we'd not dictate that, but we could work in collaboration with

various foundations. It is very much decisions that are made at the local level and we'd respect that.

MR. FARRELL: Can you talk a little bit about the role of licensed practical nurses in the system and how they may interact with registered nurses, and the division of labours between them that make sure that all of the skills of those people are being used to the maximum advantage of the system?

MS. KNOX: I'll ask Mary Ellen Gurhnam to answer that, please.

MS. GURHNAM: Thank you for that question. Licensed practical nurses are a very important part of our nursing workforce and there has been a focused effort over the last number of years to look at how we can optimize their role and scope. In this province, under the regulatory framework, licensed practical nurses work in a collaborative practice arrangement with registered nurses or other medical practitioners. They're not held accountable for the plan of care and they have a more independent role with patients who have more stable, predictable outcomes.

In the Central Zone we've done a lot of work looking at how we optimize the role of licensed practical nurses based on the needs of the patient population, and where we have determined there is a stronger role for an LPN, we've actually moved LPNs to different units where they can optimize their role. What we can't afford to do is underutilize any health professional. In some units where the patient care is just very complex and there isn't a more independent role for an LPN, we've actually changed the model of care. But we have an evidence-based, systematic approach that engages the staff in that approach so we can make sure that we have the right provider in the right place based on the patient needs.

MR. CHAIRMAN: Order. Thank you. I let that go on a little longer so you could complete the answer. We are finished with our questions; the time has expired for everyone.

Ms. Knox, I'd like to give you the opportunity to provide some closing comments.

MS. KNOX: Thank you. I would like to say to the committee, thank you for your questions. This is a very important time in Nova Scotia as we step out with a new organization. I want you to hear from us that we see this as an opportunity to stay very focused on the needs of Nova Scotians and to really move forward in a way that we provide safe, quality care for our people, that they have the ability to access when they need it and be delivered in a way that we have the right service in the right place for the right time. That means that we need to be very people focused and we need to understand that this is an organization of people providing services to people, and so how we create the workplace and engage people to come to work with us and help them stay with us and grow a career is very, very important. As we go forward, we will plan provincially, always with attention to local implementation.

I thank you very much; they were very interesting questions. For our first time at Public Accounts, I want to say thank you very much for how you have treated us, and we look forward to continued discussions. Thank you.

MR. CHAIRMAN: Thank you, Ms. Knox, I'm sure we'll have you back again sometime. I would like to thank you and your colleagues for being with us today. Our committee clerk will be following up with you directly for some of the information that members requested. Thank you once again.

We do have some committee business. We had correspondence from Service Nova Scotia and from the Department of Natural Resources. I believe everyone has received that by email. If you have any questions or if you haven't received it, please let me know.

We have a delegation that is going to be visiting with us next week, a group of four fellows from Ghana, Tanzania, and Cameroon. I would like, before everyone leaves today, if you could come to see me and let me know if you might be available to participate in a round table discussion to share knowledge with them from our experience here on this committee. That would be taking place on Monday, May 11th, at 9:30 a.m. here at Province House, so please check in on that before you go.

I believe our only other item is our next meeting, which will be May 13th, where we will have the Department of Health and Wellness to speak with us about long-term and continuing care policies. Ms. Lohnes-Croft.

MS. LOHNES-CROFT: Will we be meeting on the 27th of May? There's nothing scheduled.

MR. CHAIRMAN: No, there's nothing scheduled at this point.

MS. LOHNES-CROFT: Okay, but it could be scheduled?

MR. CHAIRMAN: It's possible. I don't think we will be, but it is possible.

MS. LOHNES-CROFT: I just wanted to know for booking things on my calendar.

MR. CHAIRMAN: Sure. After the meeting, the vice-chairman and I will be talking a little bit about our upcoming meeting schedule. Currently we don't have anything scheduled and I'm just about positive that we won't be scheduling anything for May 27th, but I'm sure you can speak with the vice-chairman later today and you'll have a firm answer on that.

This meeting stands adjourned.

[The committee adjourned at 10:57 a.m.]