STANDING COMMITTEE ON HUMAN SERVICES

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STANDING COMMITTEE ON HUMAN SERVICES

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[The committee met at 13:29.]

The Chair: — Good afternoon. If the committee members are in agreement we will move to vote off the estimates after the completion of our consideration of the Ministry of Health's estimates. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

General Revenue Fund
Health
Vote 32

Subvote (HE01)

The Chair: — So today we will resume our consideration of the estimates and supplementary estimates of the Ministry of Health, vote 32, subvote (HE01).

But I'm remiss; I have to introduce my committee members. We have Ms. Draude today, Mr. Makowsky, Mr. Steinley, and Ms. Chartier. Minister Duncan is here with his officials. Minister, please introduce your officials and if you have any other opening remarks, the floor is yours.

Hon. Mr. Duncan: — Thank you, Mr. Chair, and good afternoon to the committee members. We have a number of officials as we have in our previous two meetings. To my right is Max Hendricks, the deputy minister of Health, joining Minister Ottenbreit and myself. If we have other officials that do take part in answering questions, we'll make sure that they introduce themselves to members of the committee.

I do have just some follow-up from our previous committee meetings, some responses to some questions, so I'll maybe provide those right at the beginning and also table some documents, some documentation as well.

First, on the section related to home care and long-term care, Ms. Chartier had asked for me to table the summary document related to the two-day meeting of stakeholders in response to the CEOs' [chief executive officer] tour. So this took place in December of 2013. We called this our seniors visioning session. I'm not going to go through the document. I won't read the document out for committee members — that would take some time — but I will be tabling it right away with the committee.

As well I will be tabling the RHA [regional health authority] expenditures by fiscal year for home care over the last 10 years, so that document will be tabled as well. As well Ms. Chartier asked for the number of home care supportive services as it related to three categories of palliative, supportive, and acute over the last 10 years, and so I will be tabling an attached document that does describe those services in a table form.

Mr. Nilson had asked at our last meeting for the total of EMS [emergency medical services] billing. I will be tabling with the committee a chart that has a breakdown that does show the different billings that went back to RHAs, private insurance, or patient pay, as well as the seniors' cap program, as well as the other categories. So I will be tabling that chart with the committee. It's a pie chart that is entitled provincial ground EMS by payor. So that will be tabled.

As well Mr. Nilson requested the total cost and number of patients served by STARS [Shock Trauma Air Rescue Society] helicopter services and Saskatchewan air ambulance fixed-wing service. So I can inform the members of the committee that the total expenditure for Saskatchewan STARS helicopter service for the fiscal year ending March 31st, 2014 was $19.673 million. Of this amount, the Ministry of Health provided 10.5 million. The total missions that were completed in the 2013-14 fiscal year were 557. Patients, if not eligible for any assistance programs, are charged a flat rate of $350 per trip by the Ministry of Health. Should the helicopter not be able to land directly beside the sending or receiving facility, then ground ambulance service fees are billed by the ground ambulance provider whether they be a region-run service or a private ambulance service.

The total expenditure for the Saskatchewan air ambulance fixed-wing program for the '13-14 fiscal year was $12.973 million. The Saskatchewan air ambulance service flew a total of 1,653 trips during the 2013-14 fiscal year. Patients, if not eligible for any assistance programs, are charged a flat rate of $350 per trip by the ministry. As well ground ambulance service fees are billed by the ground ambulance provider for any ground ambulance transfers to and from the sending/receiving airstrip or airport.

Mr. Nilson also requested information on funding provided by the provincial government or Crown corporations to the STARS program. So the Ministry of Health, as I have indicated, provides $10.5 million in annual funding to STARS. Through the fundraising activities that STARS conducts, it has a total commitment of $10 million over five years from SaskTel, SaskEnergy, SaskPower, SGI [Saskatchewan Government Insurance], and CIC [Crown Investments Corporation of Saskatchewan]. So a total of $2 million is provided each year over a five-year period from those five Crown corporations.

Mr. Nilson requested a copy of a map that illustrates STARS typical response area. I can indicate to the members of the committee that the range in a map that will be tabled with the committee depicts approximate distances that the helicopter can fly within two hours and the approximate time it takes the helicopters to fly to a particular area of the province.

The AW139 is based in Saskatoon, and its range is shown from the base in Saskatoon. The Saskatoon base does also operate a BK117. The Regina base operates the BK117. The range of the BK117 is approximately 500 kilometres round trip without refuelling, and the range of the AW139 is approximately 700 kilometres round trip without refuelling. And again I will be providing a map to the committee that does illustrate the range for those helicopters.

Ms. Chartier had asked about the total cost of 3P [production preparation process] events related to our lean 3P work. So the total cost for the children's hospital was $633,000. The total cost for the Kelvington and district integrated health care facility was $419,500. The total cost for the Moose Jaw

regional hospital was 1,027,376; Prince Albert Victoria Hospital, $847,500; the Saskatchewan Hospital North Battleford, $1,340,390; the Saskatoon Cancer Centre, $656,557; and the Swift Current long-term care facility replacement, $511,020, for a total of $5,435,343.

Related to the 3P process design, so the work that did take place, I'll maybe just describe a little bit starting with the most recent. So in March 2015, Heartland Health Region 3P event in Kindersley looked at developing a more efficient and effective EMS delivery model for the region. The event involved patients, providers, and other stakeholders to discuss how to best ensure the needed health services are available and can be maintained in the future.

In June of 2014, Saskatoon Health Region did a care delivery review and design of processes and the staffing model for in-patient care delivery, focusing on the needs of patients and families and maximizing unique skills of each role on the care team.

May 2014, Five Hills Health Region did a model-of-care 3P event to support new ways of working together by members of care teams in the Five Hills Health Region.

In March 2014, Regina Qu'Appelle Health Region did a model-of-care redesign for the assessment and treatment centre to design a patient-centred clinic.

October 2012, 3sHealth [Health Shared Services Saskatchewan] did a transportation 3P to redesign transportation processes from laundry processing plants to health care facilities.

And in May 2012, Saskatoon Health Region staff did a scheduling 3P on their central staff scheduling model.

Ms. Chartier had asked questions on the kaizen fellowship program in Saskatoon Health Region and the latest update on their training and if they will return to the regular positions. Saskatoon Health Region has indicated to us that the kaizen fellowship formal learning is complete and no more tours or external coaching will occur. Until the end of June, we have each of the . . . This is from the region that they have each of the individuals in a lead role and coaching a team related to a patient-flow hoshin. And following that hoshin, they will be transitioning back into their operational roles.

And finally Mr. Nilson asked about family health benefits, about online resources for the family health benefits programs. And I would refer Mr. Nilson to Social Services as they would be in the best position to answer that question as it relates to online resources.

With that, Mr. Chair, I will table the documents that I had referred to, and we would be pleased to take questions from members of the committee.

The Chair: — Ms. Chartier, you have the floor.

Ms. Chartier: — Thank you, Mr. Chair, and thank you, Mr. Minister. Just a couple of clarifications. So with respect to the total cost of the 3Ps, did that include . . . I'm assuming not but did that include the rental or lease or purchase of those buildings factored into that, or is that separate?

Hon. Mr. Duncan: — That total includes where health regions had leased or rented warehouses. It doesn't include if it was a purchase though.

Ms. Chartier: — Okay. So for those two health regions that purchased, it's not factored in there. Okay.

Hon. Mr. Duncan: — That's correct.

Ms. Chartier: — Okay, thank you for that. Just a quick clarification, and I should recall this, but when we talk about STARS and missions, when you say 557 missions, is that total patient transfer? I know that sometimes STARS is called to a call or takes a call and then has to turn around. So I just want to confirm that that 557 is total transfer.

Hon. Mr. Duncan: — So the 557 missions in 2013-14, that is of patients transported and provided care for. That number doesn't include the times where, for whatever reason, that they are perhaps dispatched and then turn around before they take part in the care.

Ms. Chartier: — Yes. Do you have the number of that number as well, the number where they were dispatched and for any reason why they weren't able to take the call?

Hon. Mr. Duncan: — We don't have that number with us, but we can provide that number to you.

Ms. Chartier: — In light of the fact that this is the last sitting of this committee possibly, I think, will it be tabled with the committee or how . . . with the Chair?

Hon. Mr. Duncan: — I can formally table it with the committee when we have that number. But not knowing when that would be, I will certainly provide that number to you when I do have it.

Ms. Chartier: — Thank you very much. Getting on to some new questions here today, how many special advisers are there in the Ministry of Health currently?

Hon. Mr. Duncan: — There's currently one.

Ms. Chartier: — Currently one special adviser?

Hon. Mr. Duncan: — Yes.

Ms. Chartier: — Can you tell me what that job description is?

Hon. Mr. Duncan: — Most recently the one special adviser position that we do have in the ministry was the program lead working directly with our mental health and addictions commissioner. Subsequent to that, since that work has wrapped up, the special adviser is now working directly with the child and family committee of cabinet, subcommittee of cabinet, particularly working in the areas of cross-ministry coordination, things like the poverty strategy, the continued work on the mental health and addictions committee. So it's specific to that work.

Ms. Chartier: — Is that a salaried position or a contract?

Hon. Mr. Duncan: — I believe it's a salaried position.

[13:45]

Ms. Chartier: — How many . . . but will double-check? That would be great. Since 2008 how many special advisers have there been year over year?

Hon. Mr. Duncan: — Thank you for the question. For the most part, going off memory in terms of the exact dates, so the dates may be a little bit off, but there would have been one special adviser that began in 2008 that left the position in January 2014. There was a second special adviser that would have started as a special adviser in the ministry approximately 2010 until 2014. And then the third is a current special adviser that started in 2009, so three individuals, and the time frames are a little bit different for each of them.

Ms. Chartier: — And the third that you've just mentioned is the one who worked with Dr. Stockdale Winder.

Hon. Mr. Duncan: — Yes.

Ms. Chartier: — Okay. The first one from 2008 to 2014, can you tell me about that job description?

Hon. Mr. Duncan: — So the first special adviser that was in place from 2008 to 2014 would have been responsible for a variety of areas. It would have been at different periods of time, but responsible for acute and emerg, the drug plan as well. For a part of that time, patient safety also fell under this person's mandate.

Ms. Chartier: — Was that a salaried or a contract position?

Hon. Mr. Duncan: — That was a salaried position.

Ms. Chartier: — In terms of deliverables, what came of that special adviser's work?

Mr. Hendricks: — It's Max Hendricks, deputy minister. Obviously I don't have that with me right now, exactly what sort of deliverables and how that was articulated, but my recollection is, as it is for most of assistant deputy ministers or people functioning with line responsibilities, they would have a performance expectations document and then at the end of the year you would go through some sort of performance, I guess, performance measurement type of exercise. So Duncan would have had that stuff and I just don't have it with me.

Ms. Chartier: — In terms of the second special adviser from 2010 to 2014, can you tell me about that individual's role?

Hon. Mr. Duncan: — The second special adviser that we had in the ministry, that was a contract position. That was initially around the work that was being led by the Council of the Federation which did involve the health care system which eventually became the health innovation working group that our Premier Wall and then Premier Ghiz co-chaired together that involved all the Health ministers. That adviser's role then moved to include workforce planning, risk and relationship management, and our primary health services branch.

Ms. Chartier: — Sorry. Did you say that that second one was a contract position?

Hon. Mr. Duncan: — That's correct.

Ms. Chartier: — Okay. Because that's a contract position, a little bit different than a salaried position when it comes to deliverables, do you know what the deliverables on that were?

Mr. Hendricks: — Yes, we do actually have the contracts back in the ministry. I would have to go back and actually see what they specifically say but they would have outlined kind of in broad terms the areas that he was working on.

Ms. Chartier: — It was from 2010 to 2014. So was that contract renewed annually then?

Mr. Hendricks: — Yes. Well actually there were several six-month chunks and again we have to verify the dates exactly. We're just going by memory here so whether it was 2010 or 2011 I would just need to be absolutely sure.

Ms. Chartier: — Approximately, okay. No, I won't hold . . . You've made that very clear here. In terms of salaries, what has been spent on salaries on special advisers then since 2008 . . . [inaudible interjection] . . . Okay. And that would be the same with the contract then, what was paid out in the contract. So from 2008, what have we paid out for the three special advisers since that time?

Hon. Mr. Duncan: — Yes. So those amounts would be . . . They're listed in Public Accounts, but we'll go grab a couple of copies going back a number of years and get you the total before we're done today.

Ms. Chartier: — That would be great. And, Mr. Hendricks, if you could, in that list that we're keeping, just the deliverables for the contract would be great.

Mr. Hendricks: — Yes, we can provide that later. We won't have that today.

Ms. Chartier: — Okay. Thank you for that. Well we'll change themes here and move on to workplace injuries here. What are the recorded rates of workplace injuries for each health region over the last five years?

Hon. Mr. Duncan: — Ms. Chartier, the way we have this recorded, so this would be our Workers' Compensation Board claims per 100 FTEs [full-time equivalent] by RHAs. So I can give you that list over the last five years as well as what we've projected where we would finish '14-15. We don't have the up-to-date numbers on that. But I can give you, by the end of last calendar year, where we were projecting to be at the end of this year. So I'll start maybe actually with the Saskatchewan Cancer Agency.

Ms. Chartier: — Would it be possible just to have that tabled? Time is short here today. Instead of reading them into the record, if you would actually just table them, that would be awesome.

Hon. Mr. Duncan: — Yes, absolutely. I'd be happy to table this with the committee. I will say though that just to give credit where it's due, our health regions have done a really great job over the last five years of reducing their worker compensation claims per 100 FTEs. On average across the province, our RHAs are down 41 per cent and that range is as high as nearly 70 per cent in one health region. So they've done some great work, and so I'd be happy to table this with the committee.

Ms. Chartier: — Thank you. Do you break that out separately in terms of long-term care facilities as well? Do you have the recorded rates and workplace injuries in long-term care facilities for each health region?

Hon. Mr. Duncan: — So the information that I have isn't based on facility designation; it's just overall by the RHAs. I think if we were to be asked to provide that information, we'd have to go back and do a special run for the information.

Ms. Chartier: — If you could do that and provide that, that would be very appreciated.

Hon. Mr. Duncan: — We'll endeavour to provide that information. We'll first have to check whether or not it's actually possible to segregate the information to be able to distinguish where the WCB [Workers' Compensation Board] claim would have been generated, but we'll check on that.

Ms. Chartier: — Okay. Thank you. In terms of recorded rates of employee exposures to bodily fluids, do you have that number for each health region for the last five years?

[14:00]

Hon. Mr. Duncan: — Mr. Chair, we'll endeavour to provide that information. Critical incident reporting only captures when it involves a patient, not a staff member, and so it's more of an occupational health and safety. We'd have to dig back into those numbers to find that answer out.

Ms. Chartier: — In terms of workplace injuries, is there another way that they're calculated? I'm thinking about a special care aid that I know of who fell and injured her knee and had to have a knee replacement but didn't qualify for WCB. So I'm wondering if there's another way as well, outside of WCB, that injuries are recorded?

Hon. Mr. Duncan: — Sorry. Ms. Chartier, could you just kind of repeat the premise of the question?

Ms. Chartier: — I know of a case of a special care aid in a long-term care home who fell and injured her knee in the workplace and ended up needing a knee replacement but didn't qualify for WCB. So you've given me the WCB rates from health regions, but I'm wondering if there's another way as well that those kinds of injuries would be recorded.

Hon. Mr. Duncan: — Not that I'm aware of or not that we're aware of. If it was, it would either be, in a case like that I suppose it would either be deemed to be as a result of the fall, and therefore it then would be claimed by WCB. So I don't know enough about I guess the extenuating circumstances, but there really wouldn't be another way that we'd capture that. It would either be the WCB claims that we'd claim or not.

Ms. Chartier: — WCB are the only workplace injuries that you capture data for then.

Hon. Mr. Duncan: — That would be if it generates a claim to WCB, if it required somebody to be off time or off work for a time. Ms. Chartier, we'll just confer for a moment here.

Mr. Hendricks: — So in addition to workmen's' compensation claims, we also, in individual workplaces they do track injuries that may not result in a claim. This is important because it might be a strain or something that has a patient out of work for a day or two, that sort of thing, but wouldn't necessarily go to the claim stage. What we do is we actually track those at a regional level so they would appear on the visibility walls in individual facilities. We could capture those probably with a great deal of work. What we report on provincially though is the workers' compensation claims, the more serious ones.

Ms. Chartier: — But you said regionally they are . . . I just want to make sure I understand that. So they are tracked regionally in each facility.

Mr. Hendricks: — Correct.

Ms. Chartier: — And reported on the visibility walls.

Mr. Hendricks: — Correct. Because there would be injuries that would be occupational health and safety that might not necessarily, you know, result in a WCB claim.

Ms. Chartier: — Yes. Forgive my ignorance here because WCB is complicated I think for people at the best of times, if anyone's had any dealing with WCB, but I just want to understand that. So if a person, if an incident report, if a person has a back strain but it's not serious enough to . . . Can you walk me through the process, is what I'm asking here. So if someone injures themself at work . . .

Mr. Hendricks: — Ms. Chartier, we'll have to actually check into what the WCB thresholds are because when there is an injury in the workplace — for example, lift injury, a back strain, that sort of thing — there will be an incident report. And generally what's changed in health regions is actually when they do have these incidents, they converge on the injured person, try and find out what went wrong, the nature of their injuries, try and help them as much as possible to avoid a WCB claim. But at some point, if there's sick time related to an injury, you know, one or two days, it will transition into a WCB claim at some point. I just don't know what that threshold is.

Ms. Chartier: — Okay. And I know you said that getting to the breakdown to each region and then each facility would be quite an onerous job. So perhaps I would ask if I could get that for our two largest health regions, for SHR [Saskatoon Health Region] and RQHR [Regina Qu'Appelle Health Region], the number of those workplace injuries outside of WCB claims, perhaps in the last five-year time frame, if possible.

Mr. Hendricks: — We'll endeavour to get that for you.

Ms. Chartier: — Okay. Thank you. Moving on to the next

question, sort of along the same theme here, do you have the recorded rates of needle sticks for each health region for the last five years?

Hon. Mr. Duncan: — Ms. Chartier, that would I think fall under the same lines as the previous questions. We'd have to work to get that number for you.

Ms. Chartier: — Okay. Do you have the recorded rates of employee exposure — I understand this is, from my understanding, policy that you keep track of this — the recorded rates of employee exposures to bodily fluids where ongoing host exposure prophylaxis was provided in each health region for the last five years?

Hon. Mr. Duncan: — Ms. Chartier, we don't have the information here, but we're going to try to provide it to you before the end of committee this afternoon.

Ms. Chartier: — Okay.

Hon. Mr. Duncan: — And we do keep track of that, yes.

Ms. Chartier: — All on that same line then, what are the recorded rates of employee exposure to bodily fluids where a PEP [post-exposure prophylaxis] kit . . . Okay. No, I just asked you that question and that's what you were going to get for me. Some of these questions are flowing out out of concerns that we've heard from health care professionals that there's been a system-wide switch to the needles used for peripheral IVs [intravenous], so I'm just interested in knowing the reasoning behind the switch.

[14:15]

Hon. Mr. Duncan: — There was a decision to, through 3sHealth, to go with a joint contract. It was a situation where one, I know in particular, one health region had used that equipment in the past, one had not, and so there was some concern that was raised by the region that this was a new product for them to use and there was some additional I think training that was going to be required.

We're just going to check on 3sHealth whether or not they've gone back to the original supplier or whether or not they've stayed with the one contract. So we're just checking right now 3sHealth on that.

Ms. Chartier, so while we're finding that answer out, if you want to have the information on the three special adviser contracts and salary, and I'll clarify that. So going back 2008-2009, you . . . The individual as well? Like the name of the individual is what you're looking for as well?

Ms. Chartier: — Yes.

Hon. Mr. Duncan: — It's in Public Accounts, sure. So Duncan Fisher was on . . . sorry, was on salary at $132,000 . . . [inaudible interjection] . . . Yes, and that was for a partial year, so that's the only one that was in that year.

2009-10, Duncan Fisher was on salary at approximately $190,000. And for a partial year, Terry Gudmundson started on a salary and benefits at 89, just under $90,000. So that was for '09-10.

In '10-11, salary and benefits for Duncan Fisher would have been $198,000; Terry Gudmundson, $140,000.

2011-2012, Duncan Fisher, salary and benefits, $207,000; Terry Gudmundson, $147,000.

2012-2013, salary and benefits for Duncan Fisher, $212,000; Terry Gudmundson, $154,000; and a contract . . . So this is a contract, not a salary and benefits, but a contract with Perry Martin Consultants at $185,000.

And then in '13-14, Duncan Fisher, salary and benefits would have been approximately $198,000; Terry Gudmundson, $159,000; and Perry Martin Consultants, $191,000.

Ms. Chartier: — Thank you for that.

Hon. Mr. Duncan: — We're just getting in touch with 3sHealth on that last question that you asked.

Ms. Chartier: — Should we move on and go back to those? Because I have a few questions on . . . [inaudible] . . . so I'll maybe wait. Or you know what? If you're making a call to 3S, I'm wondering if there were any cost savings from the switch to the new model which is . . . The new model I understand is the Braun Introcan. So cost savings from the switch.

I'm just wondering about the rationale too. So that was my first question. So a system-wide switch and you said one health region was using them and one wasn't, and there were some concerns flagged. But I'm wondering the rationale for going with the one, the Braun Introcan, and I'm wondering if you looked into any potential safety differences prior to switching the model.

Hon. Mr. Duncan: — So a part of looking at suppliers for any products that we're trying to procure, so there is a process it goes through where we do . . . Safety is a big part of that. Cost is a factor, but certainly there would be a process that we'd go through to look at the safety and the efficacy of the product that we are using.

I believe in this case it really came down to, based on the experience of one health region that had been using this particular product where another region had not been, and it felt like there was some training that the region that wasn't . . . I believe in this case it was Regina Qu'Appelle hadn't been using it.

So when 3s is looking at any type of change or bulk procurement of products or services, you know, we do talk to clinicians as well as individuals in the health region to make these types of determination.

We're just still conferring whether or not the region that wasn't using this particular product has gone back to their previous product or whether they're still using this product with some enhanced training. We'll confirm that momentarily.

Ms. Chartier: — So just a clarification then, it is a system. It

would have been a . . . If 3s is purchasing, they'd be purchasing for all health regions then?

Hon. Mr. Duncan: — Yes, that's correct. So a big portion of 3s's mandate is to work with the health regions to identify if there are more efficient ways to procure products and services, and so this would have been a part of a process that they went through with other health regions.

Ms. Chartier: — So which health region was using them initially?

Hon. Mr. Duncan: — I believe it was Saskatoon Health Region was and Regina Qu'Appelle wasn't. I'm not sure about the other smaller regions. But I know of the two major health regions, I believe it was Saskatoon was using it previously and hadn't identified any real problems with it. And it seems like it was Regina had not been using it, and there was concerns that were raised in moving to this new product for them.

Ms. Chartier: — We'll move on to palliative care here, and I did ask some questions last time about, or two meetings ago about home care palliative care. But I think I need a little help from you understanding palliative care services. So I will ask a general question around, how many people accessed palliative care services say last year, last fiscal year in Saskatchewan? But those would be broken down, in-hospital, home care. Like am I missing anything in terms of palliative care? So just help me understand this a little bit better and then I'm looking for numbers, probably not just last year, the last five years.

Hon. Mr. Duncan: — Ms. Chartier, thank you for the question. I'll maybe just provide a little bit of an overview of what we provide for in terms of palliative or hospice care within facilities and then I'll talk about the services that are provided on a home care basis because we do provide palliative care at home, as you will know.

Regina Qu'Appelle Health Region has a nine-bed palliative care unit at the Pasqua Hospital. As well within the William Booth long-term care facility there is Grace Hospice which includes 10 beds. Saskatoon Health Region at St. Paul's, they have a 12-bed palliative care unit. Province-wide throughout a number of our long-term care facilities there would be what are known as flex beds that can be used by the regions for palliative care. So there are 255 temporary care beds in facilities that are in our special care homes and 19 short-stay beds in facilities other than those that are in special care homes. So those are all across the province. As well as in our acute care facilities across the province, there are 44 designated palliative care beds. That does include nine beds at the Pasqua Hospital, as I've mentioned, as well as the 12 beds at St. Paul's. In addition there are 118 what are considered subacute care beds that can be used by the region and the facility for a number of different functions, so observation, respite, multi-purpose, convalescence. As well they could use those for palliative care.

In terms of the use of palliative home care, I can say that over the last decade the number of clients that have accessed home care for palliative home care has increased. So I'll just give you kind of 2004-2005 as a starting date. There were just over 1,200 clients that accessed palliative nursing care in their home. In '13-14 that number was 1,974. Clients can also access as a part of . . . So this would be a part of their home care, so they could also access homemaking and meal services. And so in 2004-2005 we would have had 62 clients that would have accessed meals as a part of their palliative home care. In the last fiscal year, '13-14, that was up to 98. And homemaking, the number of clients that accessed homemaking as a part of their palliative home care went from 450 about a decade ago to 613 clients.

Ms. Chartier: — Is that chart that you've got there, is that the chart that you've tabled already, or is that a chart that you could . . .

Hon. Mr. Duncan: — Yes, that's one of the charts that was tabled.

Ms. Chartier: — I haven't had a chance to really look at them since we sat down yet. So the chart from which you just read was the tabled chart.

Hon. Mr. Duncan: — Yes, that's correct. That's the three different types of home care that are available. Palliative is one of them. And so that would be one of the charts that I did table, yes.

Ms. Chartier: — Okay. So just again, forgive my ignorance here, so you've provided me there are some places where palliative care is offered: Regina, William Booth in the hospice there; St. Paul's, and then you talked about 250 temporary or flex beds, I think you called them, and 19 short-stay beds.

Hon. Mr. Duncan: — Yes, 255 temporary beds in special care homes and then 19 short-stay beds in facilities other than, that are designated other than special care homes.

Ms. Chartier: — And then when we talked about palliative care, then you went on to talk about acute care and mentioned Regina, the hospice in St. Paul's, and then you talked about sub-acute and then home care. So when we're talking about palliative care, we talk about those three categories then: acute, sub-acute, and home care? I just want to make sure that I'm using the same . . .

[14:30]

Hon. Mr. Duncan: — Yes, the categories would be, aside from the home care-palliative care that is provided, there would be beds that would be, that could be made available within long-term care, so that's the 255 beds. Those are designated within designated long-term care, special care home facilities.

There's 19 short-stay beds that are in facilities that are not designated as special care homes. They are another designation. Then there's the 44 designated palliative care beds that are in acute care facilities. As a part of the 44, 12 of those are at St. Paul's, nine of those are at the Pasqua Hospital. The remainder would be across the province in other acute care facilities. And then there would be the 118 additional sub-acute care beds throughout the province that could be used for a variety of reasons by health regions: observation, convalescence, respite, and potentially for palliative care.

Ms. Chartier: — So we have though, here in Saskatchewan

then, 44 designated acute care-palliative care beds. That is what we have. There are beds that can be used for other reasons, but just to confirm that we have 44 designated palliative care beds.

Hon. Mr. Duncan: — So, Ms. Chartier, the 12 beds at St. Paul's and the nine beds at the Pasqua Hospital, certainly I think it's fair to say that those would be designated palliative care beds. I think the other beds, because they would be in our smaller acute care facilities, do provide for palliative care, but just based on the nature of those facilities, the population that they're serving, they may not always be . . . I think it's fair to say that it's not so much the beds in those facilities themselves that would be designated as palliative care. The facilities may be able to offer palliative care, but it just depends on whether or not those beds are needed at that time.

Ms. Chartier: — Okay. Do you have a number in terms of people who have accessed palliative care services in Saskatchewan, say for the last five years?

Hon. Mr. Duncan: — Thank you for your patience, Ms. Chartier. I will ask you to maybe be a little bit more patient on a province-wide number. We're going to endeavour to find what that province-wide number would be. But certainly for St. Paul's and the two facilities in Regina, I can go back two years for you today.

At St. Paul's, the number of total patient days in '12-13 were 4,274, and in '13-14 it was 4,298. And in Regina . . . And I don't have it broken out between William Booth and the Pasqua Hospital. I just have a total number for the beds in Regina. But in '12-13 it was 3,059 total patient days, and in '13-14 it was 2,978 total patient days.

Ms. Chartier: — Thank you for that. I just want to make sure that I'm understanding all of this. So acute care beds, those ones at St. Paul's and in Regina, the two, so St. Paul's and the two locations in Regina, you gave me 12, 10 and 9, so that's 31. Those acute care beds, are those located at hospitals throughout the province then, the difference?

Hon. Mr. Duncan: — Yes. The other beds would be throughout the province.

Ms. Chartier: — Okay. When we talked about the temporary care beds or the flex beds in long-term care as well as the short-stay beds outside of long-term care, from my understanding, palliative care is a bit of a specialty. I don't doubt the qualifications or the ability of folks who aren't in a palliative unit to provide compassionate, loving care. But am I correct in saying that palliative care is a specialty and the folks who are working at St. Paul's and in the two facilities in Regina, that's a specialty?

Mr. Hendricks: — You are correct that there are health professionals that do have a specialization, whether it be a formal designation or through experience, in palliative care. For example in Regina, they've had the benefit of having a couple of physicians over the years who have, you know, developed a specialization in this area, not so much through formalized training but probably a combination of experience and some training. Also nursing staff in our larger centres, obviously if that is their dedicated, you know, position, you develop a certain level of specialization. But I think it would be incorrect to say that nursing staff, be they home care nursing staff or acute care nursing staff in smaller facilities aren't well trained in providing . . . They do provide. They are well trained in providing palliative care.

I think through, you know, in this province there's always the opportunity if there are unique situations that develop in a smaller community to call somebody in Regina or Saskatoon who can provide them with guidance in terms of providing . . . you know, if there is something that's out of the ordinary. Oftentimes though a patient does want to be closest to home in those last days, and so oftentimes that's a factor that would be considered rather than moving them into Regina or Saskatoon where there's the critical mass to support that specialized service.

Ms. Chartier: — Just a clarification here, I was not saying that. I actually, I did say that staff have the compassion and the ability to provide good palliative care. But I guess the question was around, so the folks in Regina and Saskatoon, through experience but also through special courses probably have some extra training. And I'm just wondering what we do to support, say someone who ends up in palliative care in a flex bed in a long-term care home to ensure that they get the best palliative care? Like are there mechanisms in place in those nine beds outside of the two larger centres and in some of those flex beds and short-stay beds to make sure that staff do have the support to be able to provide the best quality palliative care?

[14:45]

Hon. Mr. Duncan: — So maybe, Ms. Chartier, I'll maybe try to address your question if I can. I'll perhaps have the deputy minister . . . But I think it really depends on if there are special supports that the individual client would need that may be beyond that facility or the providers at that facility, then there would be opportunities either to have some assistance or perhaps it may be transferring them to another location. But you know, I would say that for the most part if there aren't some special supports or services that that individual needs then, you know, by and large that the staff at whatever facility we're talking about . . .

And it also depends on how often that facility does see palliative patients being transferred perhaps back home. I know that, you know, certainly in my health region that this would be the case. And we have some wonderful nurses that provide some — I know this first-hand experience — but just great compassionate care. So it really depends on kind of what the individual client's needs are and whether or not that facility and the staff can match that and, if not, then there may be opportunities for some assistance or perhaps looking at a different facility. But by and large, you know, those supports would be in place.

Ms. Chartier: — Thank you for that. Is it possible to get a breakdown on palliative care staffing levels? Like do you actually have a breakdown for those who work in palliative care?

Hon. Mr. Duncan: — You know it would be, I'm just going to venture a bit of a guess here. For those dedicated beds within

St. Paul's, William Booth, and the Pasqua, you know, I think that we could perhaps, those would be the easier numbers to achieve in terms of providing for the committee. I think it gets more difficult when we are talking about flex beds that may not always be used for palliative care. They may be a part of the general population of long-term care beds that may be used for a time for palliative care. I'm not sure how we would provide an exact number on those types of beds, but certainly for Regina and Saskatoon, I'll see if we can provide what those staffing levels would look like.

Ms. Chartier: — And I'd be interested in those nine other beds that are included in that acute care number as well, like the 44 beds. Am I not counting that right? Twelve, ten . . . Oh no, sorry.

Hon. Mr. Duncan: — So I think our math and your math are the same, I think, on this. The extra, I think it's nine beds that we're talking about. We're going to . . .

Ms. Chartier: — Or thirteen.

Hon. Mr. Duncan: — Maybe your math is different than our math.

Ms. Chartier: — St. Pauls, William Booth, and Regina — nine beds. And there were 44, you gave me a number of 44 acute palliative care beds, so it's 13. Twenty-two plus nine is 31, and then to 44, that's 13.

Hon. Mr. Duncan: — Mr. Chair, for the committee, I'd like to confirm that it is 13 beds that we're talking about, not nine. I apologize for that . . . [inaudible interjection] . . . Okay, good. So we're going to find out exactly what facilities we're talking about. We just don't have that. Regina and Saskatoon are the main numbers, so we'll find out where exactly those beds would be, which facilities those would be for you.

Ms. Chartier: — That would be great. And then the staffing levels.

Hon. Mr. Duncan: — Yes.

Ms. Chartier: — Thank you. In terms of sort of province wide, I'm wondering what the average wait time for palliative care would be after referral to palliative care.

Hon. Mr. Duncan: — We don't track what the wait would be. I think it would be fair to say though, especially when it relates to home care palliative care, whether or not it's been determined that it is end stage or whether or not it is an earlier . . . whether or not you are end stage or not, as with home care, there's a prioritization that does take place. So it would really depend kind of where you would fall on the list, but also what your outlook is like in terms of if you're end stage or not.

Ms. Chartier: — So you don't actually track the wait time for palliative care then. No? Okay.

Hon. Mr. Duncan: — No.

Ms. Chartier: — Are there wait lists for palliative care beds in hospital?

Hon. Mr. Duncan: — So we don't track what kind of wait somebody would wait for. But you know, I think it would be accurate to say that if somebody is an in-patient in acute care, they will remain as an in-patient until a palliative care bed does open up. So typically what would happen is that they would stay in their medical bed until that time that they would have an available bed.

Ms. Chartier: — Thank you for that. I've heard from staff who work in palliative care, stories in our facilities, Regina and Saskatoon facilities, that sometimes people are admitted to palliative care, and palliative doesn't necessarily mean you're imminently going to pass away. So there's been cases where people are admitted to palliative care and spend a length of time there and then have to leave. So I'm wondering if you track those numbers at all, so where staff have to say sorry, we're sending you home.

Hon. Mr. Duncan: — We don't track the occurrences that that would happen, like the number of times that that would happen. We don't track that.

Ms. Chartier: — Have you, in your occasion as the Health minister, had that flagged for you?

Hon. Mr. Duncan: — So in my time as Health minister, I have had the opportunity to have a number of conversations with families that have used palliative care services. And just on a personal basis, I've had an opportunity to visit some people in palliative care. I'm just going off my memory. I don't think that that was . . . I don't think that was ever raised to me a scenario where somebody was in palliative care for an amount of time and then basically asked to leave palliative care. I might be wrong on that, but that concern, there were other concerns that were raised with me, but that concern doesn't come to my mind.

Ms. Chartier: — I've had it raised with staff who said it's incredibly difficult to tell a family who's getting amazing palliative care support in hospital, in the palliative care unit, and they've had to tell family or they felt that they were telling . . . had to lie to family, in essence, in saying that well, you'll get as good a service. I mean palliative home care can be awesome too, but it's not the same as . . . I have had that occasion to have staff flag that for me as a concern, because we have a shortage of palliative care beds.

On that same vein, has your government . . . Do you have any intention of generating a province-wide palliative care strategy?

Hon. Mr. Duncan: — So I would say, in a general sense, that there is interest within the ministry to continue to do some work around the issue of palliative care, certainly as it relates to the work that we're trying to do to be more patient centred. Certainly this is an important piece to that. as well as, while it's not always related or not specific to issues around seniors' care, certainly it is a topic amongst ministry staff and stakeholders when it comes to looking at the continuum of care for seniors. And in this province it's something that we need to be mindful of. So it's something that we have an interest in as a ministry to do some more work on.

But I would just maybe, you know . . . I would stop short to say that it's a part of or there is a plan to create a strategy around

palliative care. We don't have a plan at this point to do that, but it is something that is a topic of great interest within the ministry and our stakeholders.

[15:00]

Ms. Chartier: — I think I just have a couple more questions on palliative care here. And thinking about the number of beds then, have those acute care beds, the 44, how long have those beds been in place? Yes. The time frame here, those 44 beds, how long have they been in place? Has that number increased over years or have any been added in acute care over the last few years or has that been pretty stable?

Hon. Mr. Duncan: — That number has been stable over the last number of years.

Ms. Chartier: — Since when?

Hon. Mr. Duncan: — We'd have to verify how far back it would go. You know, I think in the general sense, for the last number of years it's been pretty stable. But at this point I couldn't tell you if that's the last five years or the last seven years or the last 10 years. But certainly the last couple of years it's been pretty stable.

Ms. Chartier: — When did the hospice come on board? And the hospice was a community initiative to begin with and then supported by the region?

Hon. Mr. Duncan: — The William Booth beds, we'll have an answer for you before the committee ends. We're just checking to see when exactly it opened.

Ms. Chartier: — Okay. And if you could maybe just in checking that, then I'm just trying to confirm that in fact 44 beds . . . Has it changed and when did it change? When did we add beds in that total of 44? And if two beds were added three years ago, like I'd just like to know how long we've been at 44 and like a snapshot over the last 5 to 10 years would be . . . Yes, if it's been 44 beds for 10 years, I'm just wondering . . . You get the gist of my question there.

Hon. Mr. Duncan: — Yes, absolutely we will.

Ms. Chartier: — Okay. Thank you. Oh and one more question. So around those temporary or flex care beds then, do you keep track of how many beds over the year are used for palliative care? Or like not just the temporary and flex beds but the short-stay beds, do you keep track of how many times those have been used for palliative care?

Hon. Mr. Duncan: — Ms. Chartier, I can provide for you the number of residents, of palliative residents in long-term care. So these would have been residents that would have been admitted . . . They would have been deemed to be palliative when they were admitted into long-term care. So if I can give you those numbers really quickly here, and I have back to 2009-2010, so 358. And then in '10-11 it was 398, '11-12 was 421, '12-13 was 383, and '13-14 was 407.

In terms of the overall number of . . . I think your most recent question was like the number of beds I think that had been used or the number of . . . looking beyond just the Regina and Saskatoon numbers. We could see how we would collect that information. It would be . . . I'll just say this. It'd be very difficult to try to collect that information. We'd have to merge a couple of different databases. We'd have to probably look at physician billing, who had actually submitted billing under the fee code, palliative fee code. So I don't have a number for you on that. We could look to see what that would entail, but I would just say that it would be, at best it would be an estimate.

Ms. Chartier: — Okay. I'm just trying to get a sense of, outside of those centres, what's being offered for palliative care. So in terms of palliative care in long-term care, what does that look like? If I'm in a long-term care facility in a palliative care bed, how does my care differ from someone else?

Hon. Mr. Duncan: — It would really depend on the particular circumstances of the resident that is in long-term care and have already been deemed to be palliative care. So if they are admitted as at end-stage palliative, like they've been already assessed, they've been admitted at end stage, there certainly would be a difference in terms of . . . And I won't get into the service or the clinical side just because everybody's situation would be different, but if they are designated as end stage, they would not be assessed home care fees. They would not be assessed resident charges while they're in the hospital. They would not be assessed resident charges when they are specifically admitted for end-stage palliative care for special care.

If they are assessed as stable but requiring long-term care, so they still may be palliative but they're assessed as stable, then they would still be assessed for things like their home care fees and the resident fees.

Ms. Chartier: — Thank you for that. Switching gears here again. The IV needle questions, have you been able to get those answered?

Hon. Mr. Duncan: — In terms of regional health authorities, Keewatin Yatthé and Regina Qu'Appelle Health Region were the only two that weren't using this particular supplier. In the case of Regina Qu'Appelle Health Region, or I guess in all health regions, they had the option to either go back to their original supplier or stay with the new supplier, and it's my understanding that Regina decided to stay with the new supplier.

We're still collecting some information just in terms of how that process, what it looks like and then the cost savings that they did identify through that process. I have some very high-level global numbers in terms of the 3s's savings in a number of different areas, but at this point I wouldn't have it broken down for that specific initiative. But I think it is fair to say that 3s . . . Going through this process, the regions still have the ability to either procure together, partner with 3s, or they have the decision to remain on their own.

Ms. Chartier: — Thank you. This was a question I had asked in the first committee meeting that we had around providing the number of . . . So you said you had committed to provide a head count. As well, you talked about the FTEs on the number of permanent, full-time CCAs [continuing care assistant], LPNs

[licensed practical nurse], and RNs [registered nurse]. I'm just wondering if you've pulled those figures.

Hon. Mr. Duncan: — No, we're still compiling the actual head counts separate and apart from the FTEs that we were I believe able to provide. So the head count, we are still collecting that information from the regions, and we will be providing that to you, Ms. Chartier, and to the members of the committee, but we didn't have that in time for today.

Ms. Chartier: — Okay. One thing that I'm trying to understand in terms of FTEs, when people are casual employees, how do they factor into calculating FTEs?

Mr. Hendricks: — The full-time equivalent position is the number of straight time hours paid to a specific employee, and it will vary by union. So depending on the specific leave benefits of any given union — SGEU [Saskatchewan Government and General Employees' Union], SUN [Saskatchewan Union of Nurses], whatever — the number will vary.

But just to give you an example, it's kind of in the range of 1,950 hours. So a casual working 25 per cent of the 1,950 hours would be considered a .25 FTE.

[15:15]

Ms. Chartier: — So the casuals are calculated into the FTE. When you are giving me an FTE number, casuals . . .

Mr. Hendricks: — That's correct.

Ms. Chartier: — How about folks who are on leave, like, for any particular reason? So their position is still counted, but if their position isn't filled . . . Or are they removed? Like if a person is on leave, how do you count that?

Mr. Hendricks: — All paid leave would be included in there. So if a person is away sick and that's paid leave or if they're on vacation and that's paid leave, that's included in paid leave. It's straight-time pay.

Ms. Chartier: — I think that that's the crux of when you and I were chatting in our first committee and you were giving me the number of salaried . . . or this is based on payroll. I've talked to some managers who've told me the question isn't payroll. The question is, what does the schedule look like because there are many people off sick or vacation, those kinds of things. So I've been racking my brain since that first conversation that we had because it just doesn't make sense, the anecdotal information that we're getting from facilities. But I've been told the place that we should be looking is at schedules.

Anyway could you provide the number of employees — CCAs, LPNs, and RNs — that are on sick leave and short- or long-term disability? I'd be looking at the last five years. Do you have the number of employees who have been on short- or long-term disability? Like have you calculated that? Do you keep track of those numbers for the last . . .

Hon. Mr. Duncan: — Thank you for the question, Ms. Chartier. We've already I think tabled with the committee the amount of workers' comp hours per FTE that the health region have reported over the last five years, and with a projected sixth year in that chart. Those numbers have come down quite significantly. I also can, and I don't have this broken down by the different types of facilities, but I can also indicate to the committee that sick leave hours per FTE are also, for the most part with one exception, also have been reduced since 2009-2010.

So I'll just maybe . . . And this is using at the end of December 2014, so as '14-15, a projected number. But from 2009-2010 to, projected, the end of '14-15: Cypress Health Region were on track for a 21 per cent reduction in their sick leave hours; Five Hills, a 6 per cent reduction; Heartland Health Region, a 10 per cent reduction; Keewatin Yatthé, an 11 per cent reduction; Kelsey Trail, a 4 per cent increase — That's the only increase of the group; the Saskatchewan Cancer Agency, a 12 per cent decrease; Mamawetan Churchill River, a 22 per cent reduction; Prairie North, a 25 per cent reduction; Prince Albert Parkland, a 23 per cent reduction; Regina Qu'Appelle, a 3 per cent reduction; Saskatoon Health Region, a 6 per cent reduction; Sun Country, a 20.5 per cent reduction; and Sunrise Health Region, a 12.4 per cent reduction for an overall Saskatchewan provincial average, including the Cancer Agency, of a 9.8 per cent reduction in sick leave hours per FTE.

So I think what has remained consistent — obviously people are still taking their holiday time so, you know, I think probably wouldn't factor that in — but our workers' comp numbers are actually coming down. And over the last five, six years, our sick leave hours are also coming down as well.

Ms. Chartier: — How about long- and short-term disability?

Hon. Mr. Duncan: — We would have to do some digging to find that number. At a certain point, sick time will convert over to long-term disability. But not all, I think it would be fair to say that not all long-term disability that would be calculated would be as a result of necessarily a workplace injury or something that takes place in the workplace.

Ms. Chartier: — No, no, but that doesn't mean that people aren't off work and not be . . . Like they're still included in payroll, are they not, or not on long-term disability?

Hon. Mr. Duncan: — No. I believe once they're on long-term disability, then they come off the payroll.

Ms. Chartier: — But short-term disability, they are a part of payroll?

Hon. Mr. Duncan: — Yes. We'd have to check on that, whether or not short-term disability would be calculated in the straight-time hour numbers. We'll check on that.

Ms. Chartier: — If you could check on that and get the numbers for long-term and short-term disability in the last five years to the committee, that would be very helpful.

Hon. Mr. Duncan: — We'll endeavour to provide that information to the committee. It does though depend on the union contract when sick time would . . . how quickly you would kind of burn through that before you would go on to

something like long-term disability. So it would be, each contract would be a little bit different.

Ms. Chartier: — That's okay. I'm still interested in sort of why we're at the place where you tell me that payroll hours are going up but anecdotally people are saying there's . . . Like there's got to be an explanation, and I'm anxious to try to find that explanation.

When I talked to some folks in different health care facilities, they often tell me that when shifts are filled . . . And we talked about this specifically around Providence Place, how you said numbers of filled shifts. But what I often hear is that shifts are only filled for part of that time. So if it might be an 8-hour shift, people are only called in for four hours, and not just because it's been in the middle of the night, but that is a strategic move in terms of reducing costs. So I'm wondering when you talk about filled shifts, are you talking about full shifts?

Hon. Mr. Duncan: — The number that I would have had for Providence Place, and we could check into this, I don't think it differentiated between how many of those shifts were partially filled and how many of them were fully filled. We'll check with the health region on that.

I think there are a number of factors why a shift may not be filled entirely. And one of the examples that I did give was middle of the evening, unexpected that somebody can't fill their shift, so it does take some time for somebody to come in. So they may not be there the entire . . . if it's an 8-hour shift or a 12-hour shift.

Also something that has been raised and, I even note that was on the CEO report from the 2013 Oliver Lodge CEO tour report that I think you've referenced in the last number of days, is the fact that with seniority lists, it's not just a matter of kind of going at the top of list. Well it is a matter of going at the top of the list and essentially working your way down until you can kind of find somebody to fill that shift. And I think in that facility, one of the things that was flagged was that it can, in some cases, take up to two hours just to make it through the list to find the next available person. So there are a number of factors that would cause the entire shift not to be filled by a replacement worker.

Ms. Chartier: — When we talk about filled shifts though, I think I'm looking for an acknowledgment from you that it might not be in fact an 8-hour shift when you say . . .

Hon. Mr. Duncan: — Yes. It would depend on how much notice that management would have to be able to fill that shift, you know, whether or not there's a long period of time or perhaps in some cases a very short period of time that they do know that a shift is not filled. But I will say that the employee that does come in to fill that shift, I mean, as you will know, that they are guaranteed a certain number of hours regardless of how many hours that they actually are called in for.

Ms. Chartier: — Yes. Labour standards, I believe it's three hours that they're guaranteed.

Hon. Mr. Duncan: — Yes, according to labour standards I think it is three hours, but there could be additional provisions in contracts that would go beyond the three hours. I'm not familiar with all the different . . . the SEIU [Service Employees International Union], CUPE [Canadian Union of Public Employees], SGEU, etc., but there may be different provisions depending on the union contract.

Ms. Chartier: — Do you think that short-shifting, which I've heard from not one facility but multiple facilities, could in fact be a cost-reduction strategy by managers, not because they deliberately want to short staff but they need to save money?

Hon. Mr. Duncan: — Again not knowing the provisions of all the different union contracts but knowing that a minimum of three hours have to be paid when somebody is called in to fill a shift, I guess I'm not sure there is much to be saved in terms of, you know, when a shift would be filled partially or fully, based on the fact that there would be a requirement at a minimum of three hours, again not knowing what is in each union contract. So I'm not sure how much of a factor that that would play into management's decision not to fully fill a shift because obviously there would be some cost implications to even partially filling a shift.

Ms. Chartier: — Are there some health regions requiring premium and overtime reductions and trying to limit overtime in premium hours?

Hon. Mr. Duncan: — I think it's fair to say as a ministry we're working with all of our health regions to put in place strategies with the health regions to reduce our wage-driven premiums, whether that be sick time or overtime. That's something that we do track with the health regions, that we do ask the health regions to, you know, look at ways to reduce both their sick time but as well their overtime use as well.

Ms. Chartier: — Thank you. If I could just ask the Chair if we could take a 10-minute recess?

The Chair: — We'll have to tack it on the end.

Ms. Chartier: — Okay.

The Chair: — Or we can see if my members have some questions, unless you want to be here while my members ask questions.

Ms. Chartier: — I would prefer if we just took a recess. I'm sure that there's many people sitting around the table . . .

The Chair: — We'll take a 10-minute recess then.

Ms. Chartier: — Thank you.

The Chair: — You're welcome.

[The committee recessed for a period of time.]

The Chair: — The time being 3:39, our recess is over and we are back in session. Ms. Chartier, you have the floor.

Ms. Chartier: — Thank you. I think the minister is gathering some information.

Hon. Mr. Duncan: — Mr. Chair, I just wanted to provide some additional information on a couple of matters, one that we missed off when it came to special adviser positions. So going back to 2008-2009, so this would be from April . . . I'm just not sure of the dates yet just in terms of when exactly the gentleman was hired, but Gren Smith-Windsor would have served as the acting deputy minister after November of 2007. So in that role he was paid $188,668 in wages and benefits in 2008-2009 and from then he transitioned after the permanent deputy minister was hired. He transitioned into a special adviser role that took him into the '09-10 fiscal year where in salary and benefits he earned $194,000. And then after that he was no longer serving as a special adviser to the ministry.

I just want to make a clarification on the STARS, the missions that STARS made. I'm just going to . . . So missions, STARS, what is deemed to be a mission, that includes any calls where STARS are called out. It includes when they do return to base due to reasons such as weather or ground ambulance making the decision to stand STARS down. So essentially whenever the skids are up, that is deemed to be a mission. So in '13-14 from the Regina base there were 373 missions and from Saskatoon there were 482 missions for a total of 855. The number of patients flown . . . So the total number of trips where care was rendered or a patient was transported was 557 for the year so Regina was 271, Saskatoon was 286. So just a clarification on my part in terms of what actually a mission would include so those numbers obviously would be greater because they wouldn't have rendered care or transported patients in all situations.

And also I believe on 3sHealth we have an answer. Now maybe . . . I don't know if the deputy minister can maybe just go through that when he's had a chance to look at that longer than I have.

Mr. Hendricks: — So you asked about the considerations, the safety considerations that were considered in choosing a supplier, and it's for spinal needles, IV Cathlons, and hypodermic needles. It's for all three, the contract. And the primary objectives were to minimize blood exposure to client and caregivers, a one-handed, passive needle-shielding process, and decreasing the accidental needle-stick injuries.

So Kelsey Trail and Saskatoon Health Regions were the ones that had previously used the Braun product. All other regions were required to switch, and it was Regina Qu'Appelle that did have or raise some issues with it. After undergoing some training, they were given the option of returning to their previous brand or staying with Braun. They elected to stay with Braun. This change alone in terms of the suppliers yielded in around the quarter million dollar range in savings for the health care system.

Ms. Chartier: — So when did Regina or RQHR have the opportunity to . . . When did this transpire that they had the opportunity to go back to their old supplier?

Mr. Hendricks: — The contract was awarded in 2012, and I think the issues with it emerged, if my recollection is correct, sometime in 2013. So I think they went through a bit of a process during that period. I'm not sure of the exact date they were given the option, but we could get that to you.

Ms. Chartier: — Yes. Have there been issues flagged at all since that time?

Mr. Hendricks: — None that I'm aware of. So I think that there were issues at a time where Regina Qu'Appelle, some providers were having issues with the particular product and the change. And I think that, you know, identified the need for additional training in the use of this device. It was just different than what they were used to. And that training having been provided, I haven't heard anything. But again, you know, not being on the floor, I don't hear it every day.

Ms. Chartier: — No, for sure. Okay. Thank you for that. I appreciate you providing that information here today. I'm wondering, so the opposition keeps hearing and the media keeps hearing from families who are using, now having to go to Saskatoon for pediatric intensive care services. So I'm wondering if you're tracking and monitoring whether there are additional adverse impacts on patients and families.

[15:45]

Hon. Mr. Duncan: — Thank you, Mr. Chair. Ms. Chartier, thank you for the question. So there have been no, it's my understanding, there have been no critical incidents that have been filed as it relates specifically to the change in pediatric intensive care services in Regina and moving towards a high acuity. You know, I think it's difficult for me to say right now that there have been any care incidents and care issues that have been raised because of this. Certainly we will be following up with the health region.

I think that it would be fair to say that at the time there were people that were not necessarily supportive of the change in the model of care that we had moved to. I think that there probably is still some of that that remains among individuals that were not in favour of the changes that were made.

But certainly I can say that in the deliberations that Regina Qu'Appelle Health Region and then finally the ministry went through, the intent of this was to, first and foremost, to see improved outcomes for our patients in southern Saskatchewan and ensure that we were providing the right care at the right place with the right providers, especially as it related to not just pediatric intensive care and ensuring that our youngest, most vulnerable patients had access to pediatric intensivists and subspecialists that are located in Saskatoon, but also the decision around the amalgamation of pediatrics in Regina where we had a situation where a very small portion of pediatric patients had care provided to them at the Pasqua Hospital whereas the bulk of pediatric services and other support services, such as social workers, were largely located at the General Hospital.

So nothing specific that we can point to today as it relates to the specific changes that were made. But I will acknowledge that at the time, you know, there were some people that were not happy with the decision to change and, you know, I would expect that that would be the same today.

Ms. Chartier: — What are you hearing around transport in terms of logistics and good use of resources, like whether it's air ambulance or STARS or ground ambulance? What kind of

feedback are you getting in terms of how that is working?

Hon. Mr. Duncan: — So as a ministry we certainly understand that there is an increased number of pediatric patients that would be transported to Saskatoon. I would say though that not just because of the changes that were made in Regina but certainly we just have a greater population of children in this province that would be related to some of the increasing use of the transport teams.

At the time we did dedicate funding to ensure that we did have the proper supports in place for transport. So for instance, there's funding in place to ensure that we have . . .

A Member: — Respiratory therapists.

Hon. Mr. Duncan: — Thank you. So that that is available on a 24-hour basis. So you know, we did certainly want to be in a position to be able to provide support for an increasing number of pediatric patients that would be transported.

We also ensured that we had funding available to provide coverage for the transportation but as well, under our critical care transportation policy, for a family member to accompany the pediatric patient as well as I believe we provide for things like meals and accommodations for a family member that are in Saskatoon while the pediatric patient is in hospital.

Ms. Chartier: — Thank you. I just want to talk a little bit more about the logistics of being transferred though. So can you give me a number of how many transfers have happened between Regina or southern Saskatchewan and Saskatoon now?

Hon. Mr. Duncan: — So since 2004, since the change was made, we've had 63 . . . Sorry, since 2014 we've had 63 transfers from Regina to Saskatoon, which is in line with right around what we had had for projections when the change was made. I think at that time Regina Qu'Appelle was estimating 40 to 60 a year so we're right around the top end of that range. And from other locations in southern Saskatchewan, it's been 32 transfers.

Ms. Chartier: — Okay. So from those other locations can you break that down into road ambulance versus STARS or air ambulance?

Hon. Mr. Duncan: — We'll go back and confirm with Regina Qu'Appelle to see what the split would be, but it would be our assumptions right now that the vast majority of those would have been air ambulance transfers.

Ms. Chartier: — So in terms of ensuring that air ambulance could add those extra trips, so air ambulance is two fixed-wing planes, yes? That's correct?

Hon. Mr. Duncan: — So we have three aircraft, but the aim is to have two in service at all times.

Ms. Chartier: — So every time a flight happens or logged hours, obviously you need to get to a certain amount of logged hours and then it needs maintenance. So you always have two in operation?

Hon. Mr. Duncan: — Yes, so the goal is to always have two in service, based on the maintenance schedule. You're correct. So at a certain point they have to go in for routine maintenance. So the goal is to always have two. In the event that we cannot achieve two, we do make arrangements with charter services to provide for transportation.

Ms. Chartier: — What kind of resources were put in place? I know you talked about, I think we briefly talked about this last year, but what kind of resources were put in place to ensure that air ambulance would have the resources they needed to be able to support an extra 40 to 60 transfers?

Hon. Mr. Duncan: — So there wasn't additional support for the air ambulance itself. The intent was always to have two. The aim was always to have two available at any time, two available in service with one being in maintenance. The support was really around providing for the personnel to be available to account for the greater number of patients that we would be transporting. So the ministry at the year that the change was made, we provided Saskatoon Health Region with $249,000, but that's been annualized to just under $500,000 a year to enhance their pediatric critical care transportation team.

Ms. Chartier: — Okay. So and we had this discussion too because the transport team . . . There's no longer a transport team in Regina. The transport team always has to come from Saskatoon to Regina.

I'm just wondering if you've done any analysis. So an extra 63 transfers, which is approximately what you had estimated, how do you think that that is impacting? Have you done any analysis on how that's impacting the service that air ambulance can provide generally speaking?

Hon. Mr. Duncan: — So we've actually seen quite a stable number when it comes to the air ambulance call volumes per year going back almost a decade now. So back in 2006-2007, we saw just over 1,300 patients being transported. That number grew into the 1,600's back, 2008-2009 all the way into 2011-2012.

Since that time, we've actually seen that volume come down. In '14-15, our estimate, our forecast for that fiscal year was just under 1,500, largely I would say, in part because of the addition of STARS. They would have taken some of those patients, that we would've only had at that point air ambulance call volumes.

So we're not seeing a great . . . You know, we're seeing a fairly stable number of patients being transported by air ambulance in a given year. And in fact over the last number of years, it's actually come down, you know, roughly 150, 100, 200 in the last number of years from kind of the peak of where we would have been a couple of years ago.

I also do want to mention, we did provide support. So you focused on the . . . your good question around the transport team as well, but we also wanted to ensure that we had support in place, both in Regina for moving to the high acuity and some of the changes that we made in terms of renovations and opening up some additional single rooms for other pediatric patients. So there was 1.6 million that was provided by the ministry to complete renovations at the General Hospital.

There was also additional dollars put into Saskatoon Health Region, I believe about $5 million for operating, because of the expansion to the PICU [pediatric intensive care unit] in Saskatoon. And we've also, over the last number of years, we've seen an additional complement of specialists, pediatric specialists in Saskatoon. So since 2011-2012, we've provided funding for 12 additional pediatric specialist positions in Saskatoon.

So the transport team has been a big part of that in ensuring that we can meet the volumes that we're seeing in terms of the transports out of southern Saskatchewan. But obviously we need to ensure that we're taking into account not only population growth but just the changing nature of the model of care that's being delivered between Regina and Saskatoon. And so we did provide for additional funding so that Saskatoon could increase their capacity to handle the increasing volume of pediatric patients.

Ms. Chartier: — Just with respect to air ambulance, the reason I'm wondering about an analysis is . . . Because obviously you can cite numbers peaking and then flattening and then the addition of STARS. But could numbers flatten as well because they don't have the capacity to take on more than what they can take on?

[16:00]

Hon. Mr. Duncan: — I guess as a part of every year in putting together our budget, the ministry's always looking at not just the patients that are flown per year and kind of the demand on the services, but we also have to look at the number of kilometres that are flown, the different locations that the service has flown out of. So that would all be, I think, a part of the analysis in terms of ensuring that the services and the program can meet the demand that our patients put on it.

Ms. Chartier: — When you moved to a centralized pediatric intensive care unit in Saskatoon, was air ambulance around the table when it came to . . . Obviously transport from southern Saskatchewan was a huge component of that centralization. Were they a partner in formulating the plan?

Ms. Jordan: — Good afternoon. My name is Deb Jordan, and I'm the executive director of acute and emergency services with the Ministry of Health.

So in the planning that took place prior to Regina Qu'Appelle Health Region reaching its final decision with respect to pediatric services, there was an extensive amount of discussion and work involving the clinical lead in the Saskatoon Health Region, Dr. Givelichian; the medical director for the pediatric critical care transport team, Dr. Holt; the department head for pediatrics in the Regina Qu'Appelle Health Region, Dr. Soper; as well as the program staff in the regions to look at the impact, be very clear about what the criteria would be for patients that would continue to be cared for in the high-acuity service in Regina Qu'Appelle and what would the triggers be, if you will, in terms of the patient status and criteria that would then necessitate a transport back or transport to Saskatoon, and then clearly as well to ensure that capacity is being appropriately utilized, but more importantly that families can return closer to home, what would be the criteria then for discharge out of the PICU in Saskatoon and back to high-acuity service in Regina Qu'Appelle.

Ms. Chartier: — Thank you for that. But just to the question though, if air ambulance . . . I didn't hear that in your list, but I don't know if I just missed that? Was air ambulance around the discussion?

Ms. Jordan: — So the aviation service that is provided for Saskatchewan air ambulance is provided by the Ministry of Central Services. No, they were not directly at the table. But all of the clinical and medical services that are provided for Saskatchewan air ambulance are provided through the Saskatoon Health Region.

Ms. Chartier: — So that you would say that they were an active partner around the table?

Ms. Jordan: — I wouldn't say an active partner at every meeting, but certainly we work closely with air ambulance, and discussions were had about, you know, the changes that were being contemplated.

Ms. Chartier: — Did they flag any major concerns?

Ms. Jordan: — I think it would be fair to say that the major concern that was flagged around the transport was around the capacity of the pediatric critical care transport team and the fact that initially the nurse complement 24/7 is supernumerary to the staff on the pediatric intensive care unit. Initially the respiratory therapists were not. So that was the priority, was to — as the minister has addressed — the additional resource that went in to ensure that there are supernumerary RTs [respiratory therapist] available 24/7 for the critical care transport team.

Ms. Chartier: — Is anyone from air ambulance, whether it's on the aviation side or on the clinical side, flagging concerns or challenges right now?

Ms. Jordan: — So we have been in discussion about the number of times that the critical care transport team is going with air ambulance for repatriation of patients and whether, if those are stable patients, whether the pediatric critical care transport team needs to accompany all of those patients on repatriation. As the minister noted earlier, not only the change in Regina Qu'Appelle but just the growth in the pediatric population is driving a need for pediatric critical care transports. So we're just in discussions about trying to ensure that that team is being utilized for only the care that it can provide.

Ms. Chartier: — So just in layperson's terms here simply then, there is concern that the pediatric transport team is being utilized when it doesn't need to be utilized, which means that air ambulance which is transporting them from Saskatoon to say Regina, that is a bit of a concern.

Ms. Jordan: — That would be part of the discussion as well, as to particularly on repatriations what team is being used and what's the mode of transport.

Ms. Chartier: — And just because the particular team that's being used though, that is because that team is flown from Saskatoon to Regina, that means one of the planes is being

utilized when it might not necessarily be needed to transport that team. Is that correct?

Ms. Jordan: — It will depend on the patient's condition. So a question about the time out of hospital, even for a relatively stable patient who's returning to high acuity, it may be a situation where air ambulance might be used but the pediatric critical care team possibly not. So it's kind of a combination of looking at when and where the pediatric critical care transport team, which is over and above the critical care paramedic and nurse that would accompany a normal air ambulance flight, whether it needs to accompany necessarily on all the repatriations.

Ms. Chartier: — Okay, thank you for that. I know that time is short here so I might come back to that. But you had mentioned something, Minister Duncan, around adding pediatric specialists in Saskatoon. So I'm just wondering around the opening of the children's hospital, do you have targets for physician specialist recruitment for the children's hospital when it's open?

Hon. Mr. Duncan: — So, Mr. Chair, Ms. Chartier, thank you for the question. We've been working very closely with Saskatoon Health Region looking at in light of, yes, the children's hospital opening up in a couple of years but also just, you know, what specialties and subspecialties that we need in pediatrics. So we have been going through a process where, through both the region and Saskatoon Health Region, there has been some work to identify what those types of specialties within the specialty groups would be.

So I can indicate that over the last . . . So '11-12, pediatric neurology, nephrology, general pediatrics, and respirology, those positions would have been recruited in that year. In '12-13, hematology, gastroenterology, and endocrinology — so pediatric, all of those are pediatric positions; '13-14 the focus was on neonatology, respirology again, and rheumatology. And so each year there's work being done to kind of identify what, kind of, the next group cohort is going to look like in terms of trying to fill those positions, and we're certainly working really quite closely with the health region on this.

Ms. Chartier: — So upon opening of the children's hospital though . . . So you've told me about some positions that have been filled. You said 12, I think, pediatric specialists in Saskatoon. But when you open, do you anticipate . . . Pardon me. When the children's hospital opens, do you anticipate all the positions that you've planned for being filled?

Hon. Mr. Duncan: — I would say that it's in terms of ensuring that we have all of our positions filled by the time the children's hospital opens. I think that what we're trying to do is work through a process, knowing that there will be some subspecialties that we just will not be able to recruit into Saskatchewan, based on our current demand and current volume of services.

So for instance, every year our budget contains dollars that goes into a Western collaborative when it comes to pediatric cardiac surgery. This is based on quite a tragic case out of Manitoba a number of years ago where Western provinces decided that based on such a small volume it didn't make sense for all of us to try to compete against each other to recruit a very difficult specialty. So there will be those positions that, based on the volume here or based on the fact that it would be difficult if we have the volume, but it would justify one position. Obviously we know that even in family medicine it becomes very difficult for one person to manage the workload without, you know, burning out and having work-life balance issues.

So you know, I would say that it's not as . . . You know, I don't want to leave the impression that there is kind of a number in mind at this point or a number of positions in mind at this point. It's each year we kind of work through and look at, you know, what are the demands currently today in our pediatric population. Where are the gaps in terms of being able to provide those services in an appropriate way? And kind of moving through that process each and every year.

Ms. Chartier: — So you said you're looking at demand in the pediatric population. So what are the gaps right now?

[16:15]

Hon. Mr. Duncan: — So first of all I would say that general pediatrics is something that we still need to put a focus on in terms of recruiting into those positions. In terms of the subspecialties, it's not just looking at kind of where the gaps may be today, so you know, in a number of areas: nephrology, neurology, endocrinology. So those are ones that we had identified in the past and have for the most part been successful in recruiting into those. But as well, looking at the current complement of specialists in the province and looking at, so what are our retirements that are upcoming, people looking at perhaps career path changes, moving into other areas of subspecialty?

So you know, it's always I guess kind of a moving target whenever you get into these types of positions. It's not just, you know, today we will have everything filled that we're looking for. It's a continual process to ensure that we do have those positions filled and looking at what the demand is in the province and trying to project, you know, project into the future in terms of our population and the portion of the population that will use different services at different points of their life.

Ms. Chartier: — Okay. I get the need for long-term planning and thinking about how things shift and change. And that's actually what I'm trying to get at here. So you've identified general pediatrics as one of the gaps. Do you have a sense of how big of a gap that is? Like how many, how much are we lacking there?

Hon. Mr. Duncan: — Our overall pediatric numbers have actually increased significantly over the last number of years. But as we work through this process with the ministry and the regional health authority, particularly with Saskatoon, as I've said before, you know, we still have some positions that we're going to continue to recruit into. And it's going to, you know, based on a number of factors — our population, the age of our existing workforce, I would say in a general sense . . . I mean this is ongoing work with Saskatoon Health Region, trying to kind of identify what the priority areas are. In general pediatrics, I would say, there would be a couple of . . . It's not a large number, but it's not one that I would just want to point to

and say we need X number because there is always the ability to . . . Just based on the timing of when students are graduating and the different areas that they're graduating from, you know, we may have in mind that we need two of these positions, but we have an opportunity to recruit something that maybe the region or we weren't looking at at that particular time. So there's always some flexibility in what these numbers would look like. But in general pediatrics, you know, I would say it's a couple of additional positions over the next number of years. But just in terms of whether it happens this year, next year, the year after, there's some flexibility in when that would happen.

Ms. Chartier: — Okay. Forgive me here but, so you've added 12 pediatric specialists in Saskatoon. You talked about neurology, nephrology, hematology, gastroenterology, neonatology, and I can't read the rest of my writing so that's one for *Hansard*.

So you have a children's hospital that's opening. You'll have a beautiful facility, and attached to that beautiful facility are specialists. And you want a beautiful facility with the people who can provide all the care. So I'm wondering, I still am not . . . I recognize that there's a moving target. People move. People come home, or you hire people. But I'm not getting a sense of what you want in place for staff when the children's hospital opens.

Mr. Hendricks: — So the way that I would respond to your question is, I believe that there's general agreement with the College of Medicine and the health region about the general specialities that are required for the hospital. And so you have your pediatric generalists, and then there's a list of positions that — in terms of those that we believe our population, based on its unique demographics and the numbers in this province, can provide — the minister spoke to, things like pediatric respirology, endocrinology, and then neonatology, that sort of thing.

And that gets into another area. The children's hospital really isn't just about the pediatrics and the pediatric medicine component of it. You also have pediatric surgeries. But because it's a maternal hospital as well, we're also trying to put our heads around issues related to neonatal intensive care, pediatric intensive care support, so there are a number of things.

We have to be very careful because not only do . . . you know, in terms of having 1 million people in the province, whether we could support a specialist here. But even if we, you know, did have a need, to actually maintain the service on a continuous basis, you have to have a couple or a few, and it's very hard to attract a specialist who can't maintain their skills because they're not servicing enough people.

So we have to mindful of that, but in general we have the core group of specialities. And over the next few years, you know, working with the College of Medicine and with the department head of pediatrics, we'd probably like to see four or five additional general pediatricians and then, as we can recruit to the other specialities, move it in stages because they need to have a recruitment plan where we don't want to just recruit one and only have one kind of in the bush and no more in the foreseeable future.

Ms. Chartier: — Oh, for sure. Okay. Thank you for that. Just moving on really quickly here to fire sprinklers in personal care homes. I understand that personal care homes with more than five people need a fire sprinkler, and I've heard from some fire personnel that facilities have a few years to comply or come up to code. And I've been given the date 2018, but I'm wondering if you could speak to that.

[16:30]

Hon. Mr. Duncan: — So the Ministry of Health is working closely with Government Relations as well as Social Services because a number of our different types of operations may be impacted by the date. The changes that were made to *The Uniform Building and Accessibility Standards Regulations* does give us until March 2019 for those facilities that do not have fire suppression systems, sprinkler systems, that currently have less than, I believe it's five residents. Anything over that already were required to have a sprinkler system.

This would not only be personal care homes, but also our approved mental health homes that we will have to address in some fashion. So we are still working closely with Government Relations and Social Services on kind of what the next steps are to ensure that those that aren't able to, particularly those that aren't able to self-preserve, is the terminology, how we're going to move forward on that.

Ms. Chartier: — Do you know today, as of April 30th, 2015, how many don't meet the standard, the personal care homes?

Hon. Mr. Duncan: — We have 53 personal care homes in the province that have five or less beds. Six of them do have fire suppression systems, so it would be 47 that currently do not have fire suppression systems.

Ms. Chartier: — Forty-seven that don't. What kind of support . . . So they have until 2019 to do this, you said? I believe you said 2019. What kind of support will the ministry offer to help make this happen?

Hon. Mr. Duncan: — So we are currently, as I said, having discussions with not only Social Services and Government Relations but as well as the stakeholders that would be involved. You know, we're trying to, as a government we're trying to balance off ensuring that we are having in place the right policies and procedures to ensure that people are, their safety is protected, but we're also very mindful that in many cases these are personal . . . They're peoples' private homes, especially in the approved mental health homes. And so you know, we're trying to balance off, how do we ensure that we have operators and operations that are safe but also as much as possible limit the impact that this will have on individual homes?

If you can imagine a fire suppression system that is put in after the fact, after the home is built, you know, they're on the exterior of interior walls, so you know, people are concerned about that in terms of, you know, whether or not it's aesthetically pleasing for your home, the resale value, things of that nature. So those are all the types of things that we are discussing right now.

Ms. Chartier: — That 47, is that personal care homes or is that personal care homes and mental health homes?

Hon. Mr. Duncan: — No, that's just the personal care homes.

Ms. Chartier: — Okay. Okay, sorry. Thank you. The financial component, is that being flagged as a barrier for some of these personal care homes?

Hon. Mr. Duncan: — I would say that the financial consideration is one of the considerations that is under discussion amongst the ministries as well as the stakeholder group. You know, I would say that in terms of the group that we have as stakeholders, you know, there's both the considerations in terms of just the different nature of what the two operations are like.

So personal care homes, you know, it's essentially a small business, and so these are people that are running a business whereas I would say, by and large, approved mental health homes, people are in this sector for a different reason for the most part. You know, they may have a family member that is requiring support.

And so, you know, we're mindful of, as we're looking at these types of decisions, you know, that there is the potential for a financial impact but as well as the impact on, as I said before, the considerations around, you know, whether or not somebody actually in their own home wants to have a sprinkler system installed, things of that nature. So that's a part of the discussion that we're having.

Ms. Chartier: — Okay. Thank you. I've just been told I only have about 20 more minutes here for questions. So I'm just looking at a letter that Mr. Hendricks, you had received here from the Minister of Health, saying:

> I understand the Provincial Auditor will be conducting a review of lean in 2015 as stated in the Provincial Auditor's *Business and Financial Plan*. I also understand that the Health Quality Council has contracted with the University of Saskatchewan to design a multi-year evaluation of lean deployment in Saskatchewan expected for 2014.

And then also again in the auditor's report, so this would have been told to the auditor, "Health Quality Council commissioned an independent research team from the University of Saskatchewan to undertake a multi-year evaluation of lean in the health sector."

So I'm wondering where that is. I see a letter from March 30th, 2015, saying that "The work asked of the University of Saskatchewan was not to develop a multi-year report to evaluate lean deployment in Saskatchewan."

I'm wondering how that misunderstanding could happen. Like where is the report that the . . .

Mr. Hendricks: — Sorry, can you repeat the last part?

Ms. Chartier: — So I'm looking at a letter from the Health Quality Council, March 30th, 2015, saying that the University of Saskatchewan was not to develop a multi-year report to evaluate lean deployment in Saskatchewan. So I'm wondering what the heck happened there.

Mr. Hendricks: — So the agreement that we had with the Health Quality Council to undertake an evaluation of our lean transformation in this province was basically for . . . It was under the premise that we would develop a methodology and have the researchers develop an application to the Canadian Institutes of Health Research and, based on that, whether they could lever funding and a matching grant to support that study going forward. There has been no direction by me to stop that from going ahead. So if they are successful in that application to the Canadian Institutes of Health Research, yes, they will continue their work. But that was kind of the premise under which this was all started.

Ms. Chartier: — I understand that that's what the Health Quality Council is saying now, but that's not what was told to the Provincial Auditor and that's not what the minister had written to you:

> I also understand that the Health Quality Council has contracted with the University of Saskatchewan to design a multi-year evaluation of lean deployment in Saskatchewan expected for 2014. While we anticipate the Provincial Auditor and the Health Quality evaluation of lean will prove value for money . . .

So that is a very specific kind of, very different thing from what the Health Quality Council and you are telling me now.

Mr. Hendricks: — To be clear, the research team was also to develop the multi-year design for the study. At the end of the day, if the Canadian Institutes for Health Research doesn't support them, I think we'll have some decisions to make whether we will support the study on our own, and the evaluation, or maybe take into consideration some of the reasons that the Canadian Institutes for Health Research didn't approve the study, and try and, you know, shore it up to address any shortcomings. But we're going to do an evaluation of lean in this province. Make no mistake about that.

Ms. Chartier: — You started. Dr. Thomas Rotter, on behalf of the lean evaluation team, *A First Phase Evaluation Of Saskatchewan's Lean Health Care Transformation*. That was the first part of this, I am assuming.

Mr. Hendricks: — Correct. Yes.

Ms. Chartier: — Yes. I'm sorry if I'm . . . There's not more to come?

Mr. Hendricks: — Yes. He's made his application to CIHR [Canadian Institutes of Health Research], and he's currently awaiting adjudication of his application and funding to carry forward. So if he's unsuccessful in that application, then I think that would be a point at which we would have further discussions with the HQC [Health Quality Council] and the university.

Obviously, you know, I think my staff are satisfied that the plan that's been outlined by Dr. Rotter and his team kind of meets our needs, and we supported it going forward in the application

form. So we will watch it and see what happens there.

Ms. Chartier: — Just one moment please.

Mr. Hendricks: — Incidentally, we just did provide a letter of support for the project to the Canadian Institutes of Health Research as well.

Ms. Chartier: — Okay. So I'm wondering why, though, that Minister Duncan said we could expect it in 2014.

[16:45]

Mr. Hendricks: — So not having the letter fresh in my mind, I would find it surprising that we would be conducting a full evaluation of lean after basically a couple of years into the project. You know, one of the challenges that we've had with this is that in the first few years of our lean transformation, this has been a period where we've been learning and we've been learning by doing actually and making improvements, you know, in clinical care areas and in different places throughout the health system.

The real evaluation, and if you look at the experiences of other health organizations from which we actually modelled our transformation, it's really, you start to see the big gains from this 8, 9, 10 years out, even further than that. So this evaluation, I think that our intent here is to have a complete evaluation. They're going to evaluate all aspects from the beginning to the end. So they've done the design and I don't expect to see results; they're in the application phase right now.

The auditor has said some preliminary things about in terms of what we have done on lean and that sort of thing, but that's from a financial perspective. But even on that, again because we're in a learning phase, the biggest value I think that you will see from lean will be in terms of quality and safety, but if there are financial savings that do happen to flow from it, and I believe there are because I know there are, those will grow in future years as we continue to spread it across the system.

Ms. Chartier: — Thank you. Just again from a March 30th, 2015 Health Quality Council letter regarding an access to information request about getting that proposal, it says, "The proposal that the U of S developed has been withheld under the following sections of the local freedom of information and protection of privacy Act." So there is, under advice, proposals, recommendations, analysis, or policy options developed by or for the local authority. So that was the advice from officials why it was withheld.

So I'm wondering why that would . . . Is it simply a proposal that's being withheld?

Mr. Hendricks: — I don't know what their basis for citing that section of the local authorities FOI [freedom of information] Act is. A proposal is exactly that and until I think maybe Canadian Institutes for Health Research had the opportunity to adjudicate that, I'm not sure that they would want it shared broadly, but I'm just speculating.

Ms. Chartier: — Okay. Thank you for that. Just sticking with the Health Quality Council right now here, how many FTEs are there in total?

Hon. Mr. Duncan: — Mr. Chair, Ms. Chartier, the Health Quality Council has 50 FTEs.

Ms. Chartier: — 50 FTEs? Thank you. How many are devoted to lean and kaizen activities?

Hon. Mr. Duncan: — 21 out of the 50 work in lean activities.

Ms. Chartier: — Thank you for that. Seeing that our time is short here, I'm going to be all over the place really quickly. I'm wondering if you're aware if there are any LPNs or RNs that are being contracted from out of country to work in Saskatchewan?

Hon. Mr. Duncan: — Not that we're aware of. If they were to work in the province though they'd have to be licensed by the regulatory bodies, the SRNA [Saskatchewan Registered Nurses' Association] if they're RNs, or SALPN [Saskatchewan Association of Licensed Practical Nurses] if they're LPNs, but not that it's been raised to our attention.

Ms. Chartier: — Okay. This is probably a longer and broader discussion, but I'm wondering where your ministry is at with respect to flavoured tobacco. Don't worry, we don't have time for a big and broad discussion.

Hon. Mr. Duncan: — With respect to flavoured tobacco, so I think as you'll know, the federal minister has referred, first of all, has referred the issue of e-cigarettes. I'll maybe just touch on that a little bit because I think it's a similar topic. So that's been referred to a standing committee of parliament, so we are watching to see what does come out of that with respect to those products. As well the federal minister has indicated to Health ministers that it's her intention to tighten up loopholes when it comes to the federal regulations that were put in place a couple years ago around flavoured little cigarillos or cigars. So we're watching to see, you know, what exactly is going to come out of that.

I have one thing that has been brought to my attention in terms of the advertising around tobacco and flavoured tobacco. I know that there are advocacy groups that have indicated that, you know, the use of the bright colours that denote, kind of, the flavours associated with that particular product. You know, that is one thing we should look at, so I've written to the federal minister. I've also spoken to Minister Ambrose personally about an idea that's been pursued in a couple of jurisdictions around the world when it comes to the issue of plain packaging legislation. So this would essentially see, at a national level, tobacco companies not being able to use colours or unique characterizing logos and things of that nature on their tobacco products.

What's been put in place, or has been proposed in a couple of other jurisdictions that — off the top of my head, I can't remember which ones — but that essentially tobacco companies wouldn't be able to use colours. They'd have to have kind of the same brown and yellowish packaging for all tobacco products. So that's something that I've raised personally with the Health minister that perhaps the federal government may be interested in pursuing. I don't have an answer on that, but those are some of the, kind of, my discussion points on this.

Ms. Chartier: — But looking at what other jurisdictions are doing — Ontario; Nova Scotia I think just had third reading, I think possibly even in the last day or so; Alberta — other provinces aren't just talking to the feds about what the feds are doing.

Hon. Mr. Duncan: — Yes, and again I think it's in the last year or so, year and a half certainly, in the time that this had been raised as I've been the minister, it's always a lot of talk about what other provinces are doing. But nobody has really gone to the point of actually passing legislation. I know we're getting closer to that in Canada. But you know, we're just at this point still of taking a wait-and-see approach as it relates to what other provinces are doing.

Ms. Chartier: — Well actually that's not correct. Alberta has in fact passed legislation, have they not? And well like I said, Nova Scotia's just at third reading. Like everybody is moving on this. Anyway, if you want to make one more comment, I do have one more question.

Hon. Mr. Duncan: — Yes, I would just say that I think it's again, what we hear a lot about in terms of what other provinces are doing, you know, on the face of it, it sounds like outright bans. But in fact you're right: Alberta has passed their legislation in November of last year. It's going to be effective in June, and it's going to ban all flavoured tobacco products. But it's going to exempt menthol pipe tobacco, as well as any cigars that are weighing more than 4 grams and costing more than $4. So as we've seen in other provinces when the initial plans are announced, what usually comes out of them is not exactly as it has been advertised.

So you know, I think the messaging around that other provinces are doing this, but you know, certainly it's been my experience that other provinces are . . . We're not all on the same page in terms of how far provinces are going to go. And even when provinces do make fairly big pronouncements, what seems to happen is that what they actually put in place isn't exactly what they sold.

Ms. Chartier: — Well they've done, I've . . .

The Chair: — Excuse me, being that we're now past what we've asked for time for these estimates and . . .

Ms. Chartier: — No, we're not past it yet. Excuse me, Mr. Chair, we're not past it. You said that I had until about 5 to. I have one last question.

The Chair: — I will allow one last question, and keep it short. Because I gave you one last question, you just added on to what he had. So we'll keep this short. One last question.

Ms. Chartier: — Thank you. Mr. Minister, I'm wondering where, from whom in the Saskatoon Health Region relayed the information about Peter Bowden? Who received it in the ministry, and who was it passed to in the Premier's office?

Mr. Steinley: — Point of order, Mr. Speaker. This has nothing to do with estimates.

Ms. Chartier: — It certainly does.

The Chair: — Excuse me. That point of order is well taken. This has nothing, that particular question has nothing to do with this year's budget estimates.

Ms. Chartier: — There was much more latitude in asking questions, either did . . . [inaudible interjection] . . . yes.

The Chair: — Excuse me.

> Questioning and discussion of estimates at committee meetings is normally . . . wide-ranging, but it is not limitless. As O'Brien and Bosc point out on page 1008, "The questions and discussions at these meetings are generally wide-ranging, although the rule of relevance does apply."

I have made my ruling.

So on to our voting off the estimates. Vote 32, Health, central management and services, subvote (HE01) in the amount of 10,881,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Provincial health services, subvote (HE04) in the amount of 209,655,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Regional health services, subvote (HE03) in the amount of 3,606,708,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Early childhood development, subvote (HE10) in the amount of 11,102,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Medical services and medical education programs, subvote (HE06) in the amount of 905,900,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Provincial infrastructure projects, subvote (HE05) in the amount of 12,262,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Drug plan and extended benefits, subvote (HE08) in the amount of 371,849,000, is that agreed?

Some Hon. Members: — Agreed.

[17:00]

The Chair: — Carried. Non-appropriated expense adjustment in the amount of 4,856,000. Non-appropriated expense adjustments are non-cash adjustments presented for information purposes only. No amount is to be voted.

Now I will ask a member to move the following resolution:

Resolved that there be granted to Her Majesty for the 12 months ending March 31st, 2016, the following sums for Health in the amount of $5,128,357,000.

Mr. Makowsky: — I so move.

The Chair: — Mr. Makowsky has moved. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

[17:00]

General Revenue Fund
Supplementary Estimates — March
Health
Vote 32

The Chair: — Supplementary estimates, provincial infrastructure projects, subvote (HE05) in the amount of 14,500,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Health, vote 32, 14,500,000. I will now ask a member to move the following resolution:

Resolved that there be granted to Her Majesty for the 12 months ending March 31st, 2015, the sums for Health in the amount of 14,500,000.

Mr. Steinley: — I so move.

The Chair: — Mr. Steinley. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Seeing that we're done Health, do you have any comments to wrap up, Mr. Minister?

Hon. Mr. Duncan: — Yes, I do, Mr. Chair. Just briefly I do want to first of all thank you and the committee members for having us attend over the last three Thursdays. This is always I think a great opportunity for us to talk about what we are looking to achieve, but as well some as the challenges that we have to face in the health care system. So I want to thank you for the opportunity.

Ms. Chartier, I want to thank you for your questions. This is a couple of years now that we've had the opportunity to attend estimates together, and I really appreciate the questions that you ask and the approach that you take.

And finally I do want to thank, on behalf of Minister Ottenbreit and myself, everybody that works at the Ministry of Health that helps us to prepare for estimates, not just those that you see that appear at the committee and help us to answer questions at the committee, but obviously the countless people behind the scenes that work at the ministry to provide all the information, not just as we are building a budget but obviously as we're appearing before estimates and answering questions on it. So thank you to everybody at the Ministry of Health for all the work that they do each and every day, but especially in preparing us for our appearance at estimates. So thank you, Mr. Chair.

The Chair: — I would also like to pass on my thanks to the minister and his officials for being here today and answering the questions. I apologize for missing you, Ms. Chartier. Would you like a wrap-up comment?

Ms. Chartier: — I'd like to thank the minister and the officials. I would have liked my last seven minutes of questions here because believe it or not, seven minutes, I still have many questions to ask. But thank you to the minister and to all the officials here for your time and your willingness to compile lots of information and your willingness to table those documents. That doesn't happen in every committee, so we appreciate that. So thank you.

Hon. Mr. Duncan: — Mr. Chair, I do want to really quickly add, I want to thank Ms. Charter for raising that. We will certainly . . . We weren't able to provide all the information that we committed to in tabling to the committee, so we will certainly be doing that through you, Mr. Chair, at the opportunities that we do have.

As well, Ms. Chartier, we'll be providing that information to you as well so that you don't necessarily have to wait for the committee to meet again. So we'll follow the formal process but we'll also, if everybody's okay with it, we'll be providing that information to you.

The Chair: — If you and your officials wish to leave, we're going to continue on voting off the rest of the estimates.

General Revenue Fund
Advanced Education
Vote 37

The Chair: — So we continue with vote 37, Advanced Education, central management and services, subvote (AE01) in the amount of 15,179,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Post-secondary education, subvote (AE02) in the amount of 710,742,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Student supports, subvote (AE03) in the amount of 56,553,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Non-appropriated expense adjustment in the amount of 310,000. Non-appropriated expense adjustments are non-cash adjustments presented for information purposes only. No amount to be voted.

Vote 37, 782,474,000. I will now ask a member to move the following resolution:

Resolved that there be granted to Her Majesty for the 12

months ending March 31st, 2016, the following sums for Advanced Education in the amount of 782,474,000.

Mr. Hutchinson. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

General Revenue Fund
Education
Vote 5

The Chair: — Vote 5, Education, central management and services, subvote (ED01) in the amount of 19,558,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. K-12 education, subvote (ED03) in the amount of 1,520,452,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Early years, subvote (ED08) in the amount of 66,180,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Literacy, subvote (ED17) in the amount of 2,769,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Provincial Library, subvote (ED15) in the amount of 12,744,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Teachers' pensions and benefits, subvote (ED04) in the amount of 33,557,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Non-appropriated expense adjustment in the amount of 1,850,000. Non-appropriated expense adjustments are non-cash adjustments presented for information purposes only. No amount is to be voted.

Education, vote 5, 1,655,260,000. I will now ask a member to move the following resolution:

Resolved that there be granted to Her Majesty for the 12 months ending March 31st, 2016, the following sums for Education in the amount of 1,655,260,000.

Mr. Makowsky: — I so move.

The Chair: — Mr. Makowsky. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

General Revenue Fund
Labour Relations and Workplace Safety
Vote 20

The Chair: — Vote 20, Labour Relations and Workplace Safety, central management and services, subvote (LR01) in the amount of 4,571,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Occupational health and safety, subvote (LR02) in the amount of 8,250,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Employment standards, subvote (LR03) in the amount of 2,809,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Labour Relations Board, subvote (LR04) in the amount of 1,081,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Labour relations and mediation, subvote (LR05) in the amount 802,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Workers' Advocate, subvote (LR06) in the amount of 840,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Non-appropriated expense adjustment in the amount of 122,000. Non-appropriated expense adjustments are non-cash adjustments presented for informational purposes only. No amount is to be voted.

Labour Relations and Workplace Safety, vote 20, 18,353,000. I will now ask a member to move the following resolution:

Resolved that there be granted to Her Majesty for the 12 months ending March 31st, 2016, the following sums for Labour Relations and Workplace Safety in the amount of 18,353,000.

Mr. Steinley: — I so move.

The Chair: — Mr. Steinley. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

General Revenue Fund
Social Services
Vote 36

The Chair: — Vote 36, Social Services, central management and services, subvote (SS01) in the amount of 50,504,000. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Child and family services, subvote (SS04) in the amount of 226,143,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Income assistance and disability services, subvote (SS03) in the amount of 701,041,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Client services, subvote (SS05) in the amount of 17,214,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Housing Services, subvote (SS12) in the amount of 9,235,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Non-appropriated expense adjustment in the amount of 6,610,000. Non-appropriated expenses are non-cash amounts presented for information purposes only. No amount is to be voted.

Social Services, vote 36, 1,004,137,000. I will now ask a member to move the following resolution:

> Resolved that there be granted to Her Majesty for the 12 months ending March 31st, 2016, the following sums for Social Services in the amount of 1,004,137,000.

Mr. Hutchinson. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

General Revenue Fund
Lending and Investing Activities
Advanced Education
Vote 169

The Chair: — Vote 169, Advanced Education, loans to Student Aid Fund, subvote (AE01) in the amount of 56,000,000, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Advanced Education, vote 169, 56,000,000. I will now ask a member to move the following resolution:

> Resolved that there be granted to Her Majesty for the 12 months ending March 31st, 2016, the following sums for Advanced Education in the amount of 56,000,000.

Mr. Makowsky: — I so move.

The Chair: — Mr. Makowsky. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

General Revenue Fund
Supplementary Estimates — March
Advanced Education
Vote 37

The Chair: — Vote 37, Advanced Education, student supports, subvote (AE03) in the amount of 5,400,000. This is in supplementary estimates. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. I will now ask a member to move the following resolution:

> Resolved that there be granted to Her Majesty for the 12 months ending March 31st, 2015, the following sums for Advanced Education in the amount of 5,400,000.

Mr. Steinley: — I so move.

The Chair: — Mr. Steinley. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

General Revenue Fund
Supplementary Estimates — March
Education
Vote 5

The Chair: — Vote 5, Education, K to 12 [kindergarten to grade 12] education, subvote (ED03) in the amount of 10,300,000, is that agreed?

Some Hon. Members: — Agreed.

[17:15]

The Chair: — Carried. Education, vote 5, 10,300,000. I will now ask a member to move the following resolution:

> Resolved that there be granted to Her Majesty for the 12 months ending March 31st, 2015, the following sums for Education in the amount of 10,300,000.

Mr. Makowsky: — I so move.

The Chair: — Mr. Makowsky. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

Committee members, you have before you a draft of the seventh report of the Standing Committee on Human Services. We require a member to move the following motion:

> That the seventh report of the Standing Committee on

Human Services be adopted and presented to the Assembly.

Mr. Steinley: — I so move.

The Chair: — Mr. Steinley. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

Can I have a member to move an adjournment motion?

Mr. Makowsky: — I so move.

The Chair: — Mr. Makowsky so moves. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — We stand adjourned.

[The committee adjourned at 17:16.]