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Tasmanian Government

Ref: MIN26/1613

12 June 2026

Hon Ruth Forrest MLC
Chair
Legislative Council Estimates Committee A
C/- jenny.mannering@parliament.tas.gov.au

Dear Chair

Thank you for your letter in relation to my appearance before the Legislative Council Estimates Committee A on 3 June 2026. Please find below additional information as requested by the Committee.

OUTPUT GROUP 1- SYSTEM MANAGEMENT

1.1 SYSTEM MANAGEMENT - HEALTH

1. Please provide a breakdown of the funding outlined in 1.1, including any grants or other funding items ending each year.

	2026-27 Budget	2027-28 Forward Estimate	2028-29 Forward Estimate	2029-30 Forward Estimate
	$,000	$,000	$,000	$,000
Output 1.1 - System Management - Health				
Employee benefits	81 259	76 264	72 957	74 504
Depreciation and amortisation	3 158	3 067	3 031	2 967
Supplies and consumables	22 819	21 732	22 495	23 024
Grants and subsidies	44 077	40 775	35 310	33 751
Borrowing costs	128	118	106	43
Other expenses	1 978	1 945	1 843	1 865
	153 419	**143 901**	**135 742**	**136 154**

Output 1.1 System Management - Health
Time Limited Community Sector Organisation Funding

	2026-27 Budget	2027-28 Forward Estimates[1]	2028-29 Forward Estimates[1]	2029-30 Forward Estimates[1]
	$'000	$'000	$'000	$'000
Expiring Programs				
Allied Health Scholarships	450	-	-	-
Attracting and Retaining Nurses and Midwives	2 000	2 000	-	-

Cancer Council Tasmania - North West Tasmania Cancer Supportive Care	325	-	-	-
Cancer Council Tasmania - SunSmart Schools Program	43	-	-	-
Cancer Council Tasmania - Transport2Treatment Support	155	155	-	-
Cancer Council Tasmania - Youth-Focused Campaign to tackle Nicotine Addiction	265	265	-	-
Cancer Wellness Centre	1 000	-	-	-
Community Sector Organisations Indexation	2 234	2 945	-	-
Community Transport Services Tasmania - Transport for Young People	350	-	-	-
Cystic Fibrosis Tasmania	60	-	-	-
FightMND Support	271	115	115	-
Health Consumers Tasmania - Better Health for Dorset	200	100	-	-
Huntington's Australia	70	70	-	-
Mental Health Lived Experience Tasmania	30	-	-	-
Motor Neurone Disease Association of Tasmania	110	110	110	-
Rural Alive and Well	1 943	1 943	1 943	-
The Salvation Army - Street Teams	200	-	-	-
	9 706	**7 703**	**2 168**	**-**

Notes to Table
Continuation of time limited Community Service Organisation funding will be considered as part of the annual Budget development process.

2. Please provide a copy of measures identified to meet Operational Efficiencies, including amount of saving identified, by year.

Operational Efficiency	2026-27 Budget	2027-28 Forward Estimate	2028-29 Forward Estimate	2029-30 Forward Estimate
	$'000	**$'000**	**$'000**	**$'000**
Revenue increases				
Named Referral Implementation	4 680	8 000	10 000	10 000
Full Cost Recovery for externally funded patients	5 000	11 000	11 011	11 451
Legislation Review – Fees and charges	2 000	4 000	6 000	8 000
Expenditure reductions				
Clinical Workforce Review	10 269	10 525	10 788	10 788
Enhanced Vacancy Management, Corporate Consolidation, Executive Structure Changes	29 500	73 200	73 200	73 200
Offset				
NHRA Funding Uplift	80 000	80 000	80 000	80 000
Total	**131 449**	**186 725**	**190 999**	**193 439**

3. How much of the $118 million spent to date on Horizon 1 of the Bluegum Project was spent on 'labour hire' contracts?

Of the $118 million expended to date on Horizon 1 of the Bluegum Project, $36.45 million has been attributed to labour hire contracts.

4. Provide a copy of the Independent Report undertaken in 2023-24 on the HRIS project.

A copy of the report is attached.

5. Please provide a detailed breakdown of expenditure on the HRIS during the full period it was the responsibility of the Health Department. Please include the number of FTEs dedicated to the project and vendor/contract costs.

A total of 85 state servants were dedicated to the HRIS program, comprising 41 public servants directly engaged in system procurement, design, and configuration, and a further 44 providing subject-matter expertise and supporting system preparation activities, including data remediation.

	FY 20-21	FY 21-22	FY 22-23	FY 23-24	Total
	$'000	$'000	$'000	$'000	$'000
Employee Costs	118	1,572	2,447	1,606	**5,743**
Consultant and Labour Hire	452	1,120	3,931	9,439	**14,942**
Advisory Services	-	-	70	177	**177**
Systems Integrator	-	1,805	5,419	7,395	**14,619**
IT Costs	23	218	1,774	3,568	**5,583**
Legal Fees	-	449	338	831	**1,618**
Other	2	40	611	12	**665**
Office and Support	16	244	289	39	**588**
Travel Costs	-	13	171	70	**254**
Project Costs Total	611	5,461	14,980	23,137	**44,189**
Non-Project Costs *			380	2,291	**2,671**
Total Project Costs	**611**	**5,462**	**15,360**	**25,428**	**46,860**

*Non-Project costs include salary costs of DoH staff supporting but not working directly on the HRIS program.

6. Provide a full breakdown of numbers in the Policy and Parameter Statement of the Health Administrative Parameter Adjustments for the 2026-27, 2027-28 and 2028-29 Financial Years.

	2026-27 Budget $'000	2027-28 Forward Estimate $'000	2028-29 Forward Estimate $'000
Commonwealth Own Purpose Expenses	25 320	25 829	26 345
Operational Efficiencies	11 680	23 000	27 011
Australian Government Funding	161 761	176 971	187 750
National Partnership Agreements	5 188	3 347	2 503
Prior Year Initiatives	(1 409)	-	-
Retained Revenue	9 171	9 467	16 127
Indexation	(3 414)	(9 254)	(15 564)
Whole of Government Consolidation Adjustment	1 103	1 140	1 028
	209 400	**230 500**	**245 200**

7. What is the total cost of the 29 SES and Specialist roles in the Department of Health?

There are currently 32 SES and equivalent specialist positions in the Department of Health, which may be vacant or filled by acting arrangements at any given point in time.

The 29 reported by the Secretary in Estimates was paid FTE for the pay period just prior to 31 March 2026 and therefore did not include any roles which were not filled at the time.

The total amount paid to SES and equivalent specialist positions for the period 1 April 2025 to 31 March 2026 was $7,067,300.72 (including all allowances and payments). This figure excludes acting arrangements and includes payment to one SES officer that left the Department in December 2025 and the office was abolished at that time.

8. Does the Department of Health have any contracts or advisory arrangements with any Palantir Technologies Inc. associated companies? If so, what is the nature of that contract or arrangement?

The Department of Health does not have any contracts or advisory arrangements with Palantir Technologies Inc.

9. What will you do as Minister to protect the entitlement to presumptive Post Traumatic Stress Disorder/Injury workers compensation for first responders? Is this a policy you remain committed to?

I am aware that the Workcover Board are in the early stages of commissioning a review of the Worker's Compensation Act and I will consider the outcomes of that review when that process is completed.

The focus must be on programs which allow workers to avoid trauma, and, where it cannot be avoided, ensuring we have programs in place to support the worker to process the trauma. The Department of Health participates in the My Pulse Program (managed in the Department of Police, Fire and Emergency Management) for paramedics. There are also other wellbeing and employee assistance programs available for other areas to assist in trauma processing.

When the trauma results in lost time, including via a Worker's Compensation Claim, the focus is on injury management, including rehabilitation and return to work.

10. Please provide the data on numbers of THS staff working in the three public hospitals who are on sick leave, or long term leave due to illness or injury.

Personal Leave (sick and carers leave)

During the pay period 9 May 2026, the number of paid FTE at the four major hospitals who accessed paid personal leave (one or more days of sick or carers leave) for any time during this period is outlined below:

Hospital	Paid FTE on personal leave (paid and unpaid)	% of Total Paid FTE
Launceston General Hospital	156	5.35
Royal Hobart Hospital	251	5.11
North West Regional Hospital	53	5.09
Mersey Community Hospital	25	5.01

Note:
Personal leave (sick and carers leave) covers any illness or injury that may be experienced by the employee or their household (assuming care is required). Different seasons (e.g. winter) have higher absence rates than others and absolute figures do not take into account the size of the workforce. To address these limitations, personal leave is usually reported as a proportion of the workforce (% of FTE) over time to account for both the size of the workforce and seasonal variability.

Long Term Personal Leave

The number of employees on long term personal leave (paid sick or carers) or unpaid sick leave for each of four major hospitals can be seen in the table below.

Hospital	Employees
Launceston General Hospital	0
Royal Hobart Hospital	4
North West Regional Hospital	2
Mersey Community Hospital	1
Total	**7**

Note
Long term personal leave (sick or carers) is defined as 3 consecutive months or more.
Employees who had worked for any of the time or who took any other type of leave (including recreational or long service leave) or were on workers compensation payments are not included.

Workers Compensation

The table below identifies the number of employees who were incapacitated (not at work) due to a compensable work-related illness or injury as of 11 June 2026. This includes claims for workers compensation that were not yet assessed and accepted as work-related by the Department at the time.

Staff	Physical	Psychological	Total
Launceston General Hospital	12	9	21
Mersey Community Hospital	3	3	6
North West Regional Hospital	13	9	22
Royal Hobart Hospital	23	24	47
Total	**51**	**45**	**96**

Note:
The above figures fluctuate with some cases closed or the status of capacity changing (for example, total incapacity to capacity).

11. Please provide workers compensation numbers for the years 2023-24, 2024-25, 2025-26 and 2026 to date.

Area	2023-24		2024-25		2025-26 (31 Mar)	
	New Claims	Costs $'000s	New Claims	Costs $'000s	New Claims	Costs $'000s
Physical Claims	485	$17,496	527	$24,168	365	$16,507
Psychological Claims	140	$17,163	200	$24,713	161	$20,320
Total claims	**625**	$34,659	**727**	$48,881	**526**	$36,827

Notes to table:
1. Data source: Workers Compensation Claims Dashboard, March 2026
2. "Claims" describes new claims received in the period.
3. "Cost $'000s" includes all associated Workers Compensation costs including salaries, medical and rehabilitation costs for all claims (new and carry over).
4. Line items may not reconcile with the Total due to rounding.
5. Claim numbers and costs reported previously may differ due to payment processing delays, data processing errors, timing of payments, reversals of entries, back payments and reconciliation of duplicates.

OUTPUT GROUP 2- HEALTH SERVICES

2.1 ADMITTED SERVICES

1. Please provide a list and outline of all programs that will be included in the new Intermediary Care portfolio.

Intermediate Care comprises a coordinated suite of services that provide short-term, multidisciplinary care in the community as an alternative to, or in support of, hospital care.

Key programs include:

Rapid response

- Community Rapid Response Service (ComRRS)
- Rapid Access Inreach Service (RAIS)
- Community Paramedic services

- Ambulance Tasmania Secondary Triage
- PACER (mental health crisis response interface)

Virtual care and digital-enabled services

- Care@home (including state-wide virtual monitoring and chronic disease management)
- Virtual Emergency Department (VED)
- Virtual Multidisciplinary Outreach Service (VMOS) for residential aged care
- After-hours palliative care (via Care@home)

Community health and multidisciplinary care

- Community Nursing Services
- Community Allied Health Services
- Nurse Practitioner services
- Non-clinical support services (including TasHACC and the Community Home Support Program)

Specialised intermediate care services and community-based acute/subacute care

- Hospital in the Home (HiTH) acute-level care (including mental health) that would otherwise be provided in the hospital setting.
- HiTH Geriatric Evaluation and Management (GEM) and Interim Care Services - specialised interdisciplinary care to older patients who require Comprehensive Geriatric Assessment and management.
- Other HiTH subacute care services (including rehabilitation and specialist palliative care).

System integration and partnering services

- Medicare Urgent Care Clinics
- General Practice
- Healthdirect and after-hours pathways
- 1800 MEDICARE
- Residential Aged Care Homes

2.2 NON-ADMITTED SERVICES

1. What is the current processing time for reporting of x-rays state-wide, both for in-house and contracted services (i.e. targets, and are they being met?)

There is no nationally mandated reporting timeframe for routine x-rays in Australian public hospitals. Reporting is prioritised according to clinical urgency, with emergency, critical care, trauma, paediatric, and suspected cancer cases prioritised ahead of routine imaging.

Non-urgent x-rays are regularly outsourced to private providers, which is standard practice across the country. Private providers are utilised to help reduce waiting lists and ensure

patients receives the best possible care as soon as possible, at no cost to the patient. As these are non-urgent cases, and follow private reporting processes, turnaround times are not collected by the Department of Health.

Across all major hospital sites, Emergency Department imaging is prioritised, with a target turnaround time of reporting of less than 24 hours, which is achieved on most occasions. However, all x-rays are available to clinicians to review immediately, while awaiting formal reporting. Emergency Department imaging is also reviewed by senior Emergency Department clinicians during patient assessment and treatment, adding an additional layer of clinical oversight.

2.3 EMERGENCY DEPARTMENT SERVICES

1. Does the Health Department have in place any air cleaning measures, including HEPA filters or UV light technology, in any Emergency Department waiting room across the three major public hospitals?

a) If so, what type of technology or measures are in place?

The Department of Health implements a comprehensive suite of infection prevention and control measures within Emergency Departments to reduce the risk of transmission of infectious diseases. HEPA filtration units are available and are deployed when clinically appropriate, in line with guidance provided by Infection Prevention and Control Units (IPCU) and relevant departmental policies. Decisions regarding the use and placement of these units are made based on clinical assessment, patient presentation, and environmental factors.

b) How is the air quality in Emergency Department waiting rooms measured in order to prevent nosocomial transmission of infectious diseases to staff and patients?

Emergency Departments adopt a risk-based approach to infection prevention and control, integrating building ventilation systems, patient screening protocols, environmental cleaning practices, and guidance from IPCU. Air quality management is maintained through compliance to applicable building, ventilation, and healthcare facility standards. Where indicated, additional mitigation strategies, including the use of portable HEPA filtration units, may be implemented following an infection prevention and control assessment.

c) What is the Department of Health's policy and practice to protect staff and patients from preventable nosocomial infections within Emergency Department settings?

The Department of Health implements a comprehensive range of infection prevention and control measures to minimise the risk of healthcare-associated infections within Emergency Departments. These include:

- The provision of masks for patients, visitors, and staff from the point of entry, supporting protection where respiratory symptoms or infection risks are present.

- Assessment of respiratory symptoms during triage, with patients isolated or managed in appropriate clinical areas from the point of entry where clinically indicated.
- Use of established screening tools across the Tasmanian Health Service to enable early identification of infectious risk factors and the timely application of isolation and transmission-based precautions.
- Deployment of HEPA filtration units and other environmental controls in accordance with IPCU advice and departmental guidelines.
- Routine cleaning of waiting areas and clinical spaces, with additional cleaning undertaken as required in response to identified risks.
- Implementation of hand hygiene programs, supported by accessible hand hygiene stations throughout Emergency Departments.
- Mandatory infection prevention and control training for staff to ensure consistent application of current evidence-based practices.
- Ongoing oversight, guidance, and support from IPCU teams.

In addition, healthcare-associated (nosocomial) infections are routinely monitored through IPCU-led surveillance activities. This surveillance informs the identification of emerging trends, supports targeted interventions, and contributes to continuous quality improvement in infection prevention and control practices across the health service.

Collectively, these measures reduce the risk of infectious disease transmission and support the safety of patients and healthcare workers.

2.4 COMMUNITY HEALTH SERVICES

1. How many breast screens were performed in the last financial year that both mobile units were operating? How many were performed in the most recent period available?

Financial Year	2023-24	2024-25	July 2025 to March 2026
Number of women screened	34 923	34 799	23 823

Notes to table:

Data as per the Australian Institute of Health and Welfare (AIHW) BreastScreen Australia monitoring report 2025 and the previous year. 2026 data is yet to be fully released by the AIHW.

2. Please provide a breakdown of funding across the different community health services funded through the 2.4 appropriation.

	2026-27 Budget	2027-28 Forward Estimate	2028-29 Forward Estimate	2029-30 Forward Estimate
	$'000	$'000	$'000	$'000
Revenue from Appropriation - by Service				
Output 2.4 - Community Health Services				
Aged Care Assessment Program	761	708	733	752
Arch State-wide	318	318	318	318
Beaconsfield Multi-Purpose Service	3 809	3 543	3 666	3 760
Bicheno Medical Centre Expansion	500	-	-	-
Boosting Access to Life-Saving Breast Screening Across Tasmania	7 700	7 700	7 700	7 700
Brighton Health Centre	229	213	221	226
Burnie Community Health Centre	138	129	133	137
Campbell Town Multi-Purpose Service	4 409	4 100	4 244	4 352
Care@Home	8 000	8 000	8 000	8 000
Central Highlands Health Centre	876	815	843	865
Child Health And Parenting Service	22 697	21 109	21 847	22 405
Clarence Health Centre	724	674	697	715
Community Palliative Care North	2 353	2 189	2 265	2 323
Community Palliative Care North West	6 438	5 988	6 197	6 355
Community Palliative Care South	2 750	2 558	2 647	2 715
Community Rehabilitation	1 322	1 230	1 273	1 305
Continuing New Era of Health Care: Nurse Practitioners	225	225	225	225
Deloraine Hospital	3 580	3 329	3 445	3 534
Devonport Community Health Centre	869	808	837	858
Esperance Multi-Purpose Centre	1 440	1 340	1 386	1 422
Family Violence Counselling and Support Service	3 113	2 895	2 997	3 073
Flinders Island Multi-Purpose Centre	3 657	3 401	3 520	3 610
George Town Hospital	4 340	4 037	4 178	4 285
Gidget House - Perinatal Mental Health Services	40	40	40	-
Glenorchy Health Centre	833	775	802	823
Home And Community Care	41 546	38 640	39 990	41 012
Huon Community Health Centre	678	630	652	669
King Island Hospital and Health Centre	2 787	2 592	2 683	2 752
Kings Meadows Community Health Centre	454	422	437	448
Kingston Health Centre	408	379	392	402
Longford Community Health Centre	221	205	212	218
May Shaw Health Centre	307	285	295	303
New Norfolk District Hospital	4 392	4 084	4 227	4 335
North East Soldiers Memorial Hospital Scottsdale	3 549	3 300	3 416	3 503
Operationalising Australian Government Funded Aged Care Beds	740	2 546	2 644	2 746
Oral Health Services	35 188	32 726	33 869	34 735
Palliative Care Whittle Ward	889	827	856	877
Patient Transport Assistance Service	857	797	824	846

	2026-27 Budget $'000	2027-28 Forward Estimate $'000	2028-29 Forward Estimate $'000	2029-30 Forward Estimate $'000
Pharmacy Scope of Practice	525	525	-	-
Ravenswood Community Health Centre	509	473	490	502
Rosebery Community Health Centre	2 806	2 610	2 701	2 770
Smithton District Hospital	3 004	2 794	2 892	2 966
Sorell Health Centre	194	181	187	192
Southern Midlands Multi-Purpose Centre	2 132	1 983	2 052	2 105
St Helens District Hospital	4 537	4 219	4 367	4 478
St Marys Community Health Centre	4 021	3 739	3 870	3 969
Tasman Community Health Centre	962	895	926	949
Ulverstone Community Health Centre	132	123	127	130
West Coast District Hospital	3 194	2 971	3 075	3 153
Westbury Community Health Centre	994	925	957	982
Wynyard Community Health Centre	44	41	42	43
Youth Health North	573	533	551	565
Youth Health North West	322	300	310	318
Youth Health South	996	926	958	983
	198 083	**186 796**	**192 217**	**196 711**

3. Please provide an indication of any specific initiatives for which funding is ending in the 2.4 appropriation in 2027-28, and the amount of funding allocated to these initiatives in 2026-27.

Funding is concluding for the Bicheno Medical Centre Expansion, which received a one-off allocation of $500,000 in 2026–27. The expansion will provide additional consulting rooms, increase appointment availability for residents, and create opportunities to host GP trainees, allied health professionals, and nurses, contributing to workforce growth in the region.

4. How much in total is the government investing in breast screen services in 2026-27 and over the forward estimates?

	2026-27 Budget $'000	2027-28 Forward Estimate $'000	2028-29 Forward Estimate $'000	2029-30 Forward Estimate $'000
Breast screen funding - appropriation	14 147	14 308	14 473	14 642

2.5 STATEWIDE AND MENTAL HEALTH SERVICES

1. Please provide regional data related to access of all services provided under Perinatal Mental Health services.

Regional data is provided from 2023-24 as this is when data could most reliably be attributed at the regional level.

Statewide Mental Health Services (SMHS)

Data for SMHS Perinatal North, Perinatal North West, and Perinatal and Infant South is provided below:

Table 1: Total consumers registered for service

Service	2023-24	2024-25	2025-26	Unique Total*
Perinatal North	89	118	87	**205**
Perinatal North West	118	167	141	**286**
Perinatal and Infant South	311	479	441	**940**
Unique Total*	**475**	**750**	**654**	**1,431**

** The Unique Total counts each client once only, regardless of how many services they received. Adding the service rows together would count clients seen by multiple services more than once.*

Table 2: Total referrals received for service

Service	2023-24	2024-25	2025-26	Total
Perinatal North	79	87	66	**232**
Perinatal North West	113	121	112	**346**
Perinatal and Infant South	279	403	378	**1,060**
Total	**471**	**611**	**556**	**1,638**

Table 3: Total occasions of service delivered

Service	2023-24	2024-25	2025-26	Total
Perinatal North	711	2,006	1,521	**4,238**
Perinatal North West	1,580	2,276	2,722	**6,578**
Perinatal and Infant South	5,150	4,424	3,153	**12,727**
Total	**7,441**	**8,706**	**7,396**	**23,543**

Table 4: Average length of engagement (days)

Service	2023-24	2024-25	2025-26	Total
Perinatal North	161	143	123	**142**
Perinatal North West	168	144	123	**145**
Perinatal and Infant South	99	112	91	**101**
Total	**143**	**133**	**112**	**129**

Table 5: Percentage of referrals by received by age group

Service	<18	18-24	25-64	65+
Perinatal North	2%	26%	72%	0%
Perinatal North West	3%	24%	73%	0%
Perinatal and Infant South	1%	23%	75%	0%

Table 6: Percentage of referrals completed by Health of the Nation Outcome Scales (HoNOS) Outcome (requires 2+ assessments for comparison)

Service	Significant improvement	Significant deterioration	No significant change	Insufficient assessments, i.e., only 1 recorded
Perinatal North	29%	5%	30%	36%
Perinatal North West	35%	5%	23%	37%
Perinatal and Infant South	24%	3%	19%	54%

Child Health and Parenting Service (CHaPS)

Data for CHaPS appointments related to perinatal mental health support delivered by Child Health and Family Nurses and Allied Health Professionals (Social Workers) is provided below.

Table 7: Total appointments for Nurses

Service	2023-24	2024-25	2025-26	Total
North	114	47	62	**223**
North West	208	41	99	**348**
South	187	150	231	**568**
Total	**509**	**238**	**392**	**1,139**

Table 8: Total appointments for Allied Health

Service	2023-24	2024-25	2025-26	Total
North	64	85	81	**230**
North West	7	52	96	**155**
South	1	13	5	**19**
Total	**72**	**150**	**182**	**404**

Table 9: Total service hours for Nurses

Service	2023-24	2024-25	2025-26	Total
North	167	46	46	**259**
North West	174	24	55	**253**
South	227	128	155	**510**
Total	**568**	**198**	**256**	**1,022**

Table 10: Total service hours for Allied Health

Service	2023-24	2024-25	2025-26	Total
North	91	122	107	**320**
North West	9	63	118	**190**
South	1	10	3	**14**
Total	**101**	**195**	**228**	**524**

2.6 AMBULANCE SERVICES

1. Please provide a breakdown by category and region of ambulance call outs/responses to end of March 2026, and for previous financial year.

Incidents		Grade					
Year	Region	0	1	2	3	4	5
2025-26 to March	North	296	9,933	4,879	1,966	1,276	147
	North West	274	7,893	4,128	1,641	1,079	102
	South	608	19,213	8,254	2,465	1,408	193
2024-25 to March	North	236	8,604	4,556	1,747	1,552	150
	North West	183	7,014	4,138	1,997	1,496	133
	South	435	16,722	8,160	2,630	1,836	208

Notes to table:

Table provides count of EMS Incidents where an Ambulance arrived on scene.

2. Please provide the median response time for ambulances, by region and category, to end of March 2026 and for previous financial year.

Median Response Time		Grade					
Year	Region	0	1	2	3	4	5
2025-26 to March	North	10.2	14.7	37.1	51.7	50.9	52.3
	North West	9.1	13.1	30.4	46.5	44.9	54.2
	South	10.9	17.4	51.1	63.9	65.7	69.6
2024-25 to March	North	9.6	14.2	31.3	50	46.8	50.5
	North West	9.3	12.3	25.6	42.7	40.7	49.6
	South	11.2	17.2	46.4	62.1	65.4	67.2

3. How many times in the past year have Ambulance Tasmania resources been used to attend private events (contracted)?

Ambulance Tasmania provided crews to support 54 separate private events across 2025-26.

a) How much revenue has been raised through these contracts?
Ambulance Tasmania has collected $222,968.89 in revenue for 2025-26 from provision of crews to support private contracted events.

b) On how many occasions have resources been diverted from AT to private contracted events and left AT short?

All additional shifts to support private events are offered as overtime shifts to AT paramedic staff, as surplus to standard rostered crews. There have been some minimal and very infrequent occasions where Ambulance Tasmania has diverted resources from a shift to cover a contracted private event. Some of these have been part-shift coverage due to unplanned sick leave and other operational requirements.

4. What is the total number of hours of overtime worked by paramedics in 2025-26 to date?

56,437 hours of overtime have been worked by paramedics in 2025-26.

a) How much has been spent on paramedic overtime in the first five months of 2025 and how does that compare to the first five months of 2026?
2025 (January to May): $ 4,782,462

2026 (January to May): $ 5,727,028

5. How many paramedics are on extended sickness or injury leave, or workers compensation leave, as at 3 June 2026?

As of 9 May 2026 there was one paramedic on extended personal leave (sick and carers leave) or unpaid personal leave. Extended personal leave is defined as three consecutive months or more.

Workers Compensation

Staff	Physical	Psychological	Total
CMHW - Ambulance Tasmania	7	19	26

Please note the above is as of 11 June 2026 and includes all Ambulance Tasmania staff, not solely paramedics.

2.7 PUBLIC HEALTH SERVICES

1. Has there been any increase in hepatitis A, B or C rates in children under the age of 18 in Tasmania since 1 January 2020?

a) What is the current number of children with any diagnosed form of hepatitis?

There has been no recent increase in notifications of hepatitis B or C among persons aged less than 18 years in Tasmania. The three notifications of hepatitis A recorded in 2024 and 2025 were all acquired overseas, consistent with the typical pattern observed in sporadic cases of hepatitis A. Notifications of hepatitis A, B and C among persons aged less than 18 years in Tasmania are as follows:

	2020	2021	2022	2023	2024	2025	2026 (to 3 June)
Hepatitis A	0	0	0	0	1	2	0
Hepatitis B	2	1	0	0	0	0	1
Hepatitis C	3	1	1	0	0	0	0

Notes to table:

These notifications represent approximately 1 per cent of all hepatitis notifications over the period.

In relation to the current number of children with any diagnosed form of hepatitis, data held by Public Health Services are limited to notified cases of specific notifiable conditions, including the three more common hepatitis viruses outlined above. These data holdings do not capture the full range of hepatitis diagnoses. Hepatitis may arise

from a variety of non-notifiable causes, including medications, autoimmune conditions, toxins, and other viral infections such as Epstein-Barr virus.

2. Similarly, has there been any increase in diabetes 1 or 2 in children under the age of 18 since 1 January 2020?

a) What data is available on childhood diabetes rates and/or prevalence in Tasmania?

Tasmania-specific data on childhood diabetes is available, but it is not published as a single consolidated report. Available evidence indicates an increase in Type 2 diabetes among children and adolescents in Tasmania since 2020. This is consistent with national and international trends. Type 1 diabetes remains the most common form of diabetes in children, with overall incidence relatively stable.

Yours sincerely

Hon Bridget Archer MP
Minister for Health, Mental Health and Wellbeing

Attachment 1 - HRIS Program Review - Final Report

K&L GATES

HRIS Program Review - Final Report

Subject to Legal Professional Privilege

TABLE OF CONTENTS

1. Summary

The findings from this review underlie the likelihood that the Departments operations will be impacted, costs will increase and the Departments' reputation potentially affected, should the program continue in its current form.

The table below summarizes the identified thematic observations as at 21 March 2024, and includes our assessment of the risk position

Review Scope	**Risk to Program Objectives**
Governance	
Program Delivery	
Operating Model	
Testing	
Concurrent Employment	
Change Management and Training	

Current Risk Rating *Expected Risk Rating*

2. Background

The purpose of the review is to:

- Assess identified risks in the Project, and whether the proposed mitigations are reasonable; and
- Identify any further risks that have not been tracked.

The review will involve interviews with key project resources and Department stakeholders (covering the technical/SI stream, change management and training and the business).

The review will also involve a review of key project artefacts related to the following areas:

- Governance
- Project Delivery (eg Project Plan and Resource Schedule)
- Operating Model
- Deployment
- Testing
- Concurrent Employment
- Change Management and Training
- Comment on the adequacy of mitigation strategies of the known risks, and propose any additional strategies for consideration; and propose mitigation strategies for the discovered/unknown risks

3. Findings

3.1 Governance — Risk Rating - Extreme

a) The **overall governance** of the program is not effective. The Program lacks the required decision-making framework and committee representation (refer to Appendix B and C for examples) to effectively consider the status of the program, including issue escalation and resolution. For example: the current structure has not effectively engaged Business Process Owners to support the Program with advice and decisions.

b) The Program did not address the **transformational elements** of the scope in Enterprise Design. These aspects include a range of Key Design Decisions (KDD) which support the rationale for the Program, including; Rostering process improvement and rules alignment; Operating Model; Organization structure. The Program chose to address these KDD's later in which has heightened the likelihood of rework and additional costs.

c) The Program has moved in and out of key phases of the project without meeting the entry and exit criteria. This situation has created a significant cost risk to the project as rework will be required to address the issues associated with an incomplete solution.

d) The lack of adherence to gate criteria highlights a significant flaw in the governance of the Program. This issue is symptomatic of the following.
   - The Program Team have not communicated to the Program Leadership areas in which aspects were not complete. Therefore that has been not been an awareness of the status, risks and issues associated with moving into a new phase.
   - DXC have been remiss in their obligations to advise the Department of the risks and issues of this approach.
   - The Steering Committee does not have the required experience to assess the material provided by the Program Team to make an informed decision.

3.2 Program Delivery — Risk Rating - Extreme

a) The **Program structure** is not consistent with best practice for an ERP led business transformation initiative. Business transformation programs require close collaboration between the technical/functional teams and the business. The current structure separates the technical/functional and business functions which creates a significant risk to the viability of the solution and cost creep.

b) There are **inconsistent views from the Program Team on the rationale and benefits** of the Program. These range from a technical implementation to address a "burning platform" through to the Transformation of the business. To address this issue the Department should ensure that appropriate mechanisms and structures are implemented to enable sufficient consideration of broader transformation outcomes across the organization and begin to drive strategic thinking on the future-state.

c) We have observed that the Program has experienced ongoing challenges associated with maintaining a stable program leadership, team and structure. **The Program has not been able to assign the required business resources** which has impacted the Programs ability to address KDD's in the early phases of the Program (Enterprise Design Phase). This has led to an incomplete design and build of the solution, undefined target operating model, ineffective change management and communications.

d) The Program lacks a **method** which governs the delivery. The Program is focused on the completion of tasks as they relate to the Statement of Work (SOW) which dilutes the ability of the Program to manage dependencies including other technology and business programs. Generally, the Systems Integrator (SI) provides a delivery method which the Program works within. This has not been provided which is a serious issue that was contrary to the representations in the sourcing phase.

e) The **Data stream** has been effective in data preparation. Given the flaws in Enterprise Design, where the target state operating model and end-to-end business process was not defined, the Data team do not have the clarity on the data required by the business to support the operation. This situation impacts data archiving, reporting and the whole data migration process.

f) **Business Readiness** is reliant on the resolution of key design decisions such as, future state operating model and future state rostering processes, governance and rules alignment. These KDD's have not been settled and as such, the Business readiness stream is ineffective.

g) From a project structure and governance perspective, Business Readiness should be led by a senior business executive who understands the current state and will be able to advise the Steering Committee on the risks and challenges of new processes as well as assisting in guiding the business on the required activities to be undertaken in advance of the go live event.

h) **DXC has not been able to provide the required leadership and capabilities** of a global tier 1 SI which has contributed to many of the current risks and issues. Going forward, consideration of DXC's skills to support the Program's transformation agenda needs to be assessed and compared with other firms.

i) **"Ways of working"** is a key factor in how the Program Team, Business and Vendors deliver the Program. We have observed that many of the Program team (Department and DXC) work remotely and communicate via Teams. Whilst this approach was relevant during COVID, it is not effective in the transfer of knowledge and collaboration between all stakeholders which has contributed to many disconnects between the technical and business streams.

j) There is **a lack of involvement from the product vendors, SAP and UKG**. Their role in the implementation is to provide advice to the Department on the suitability of the design as it relates to their cloud solution. This lack of engagement creates a risk on the suitability solution and long-term support requirements and costs of the solution.

3.3 Operating Model — Risk Rating - Extreme

a) The **Operating model for the target state is not defined**. SOW 3a sets out the requirement for DXC to prepare a interim state Operating Model. The Department's Operating Model should have been settled in the Enterprise Design Phase as it informs the end-to-end business and system process, Change Management Impact, Training and Business Readiness. The impact of delaying the Operating Model will have time and cost implications for the Project and rework will be required.

b) DXC does not have the skills to assist the Department with the preparation of a target state Operating Model. DXC is a highly capable technology firm however, business transformation which includes guidance on suitable operating models is not a core competency. As part of the interview process, this matter was confirmed by the DXC Program Director.

3.4 Deployment — Risk Rating - Extreme

a) The process to prepare the **deployment plan** is flawed. The current process entails the preparation of models which are developed in isolation from the Program Team and the Business. Unfortunately, the assessment of any deployment plan requires clarity on the operating model. As previously discussed, the operating model is central to many Program activities. Future work on deployment plans and options should be halted until the operating model is confirmed.

3.5 Testing — Risk Rating - Extreme

a) The Program **commenced Systems Integration Testing (SIT) in mid-2023**. The initial SIT cycle was completed in 15 weeks and a 2nd cycle is being considered after the current Program Pause. Commencing SIT in 2023 is a good example of the lack of compliance with the Build Exit and SIT entry gate. Specifically, the build was not complete at the commencement of SIT (note, the design and build remains incomplete) and as such the end-to-end testing of the solution could not be effectively executed.

b) SIT cannot commence until the solution is built in accordance with the Requirements, Design (including KDD's) and subsequent Build and Unit test. If DXC's method suggests aspects of SIT can commence in advance of the completion of the Build phase, then DXC should provide the Department with their method for consideration.

c) The Department approved DXC's deliverable acceptance certificate which stated DXC has met the exit criteria for SIT. The sign off of an incomplete solution raises serious concerns regarding the capabilities of the technical and testing leadership. The approval of SIT places the Department in a unfavourable position regarding any recourse with DXC.

3.6 Concurrent Employment — Risk Rating - Extreme

a) There are inconsistent reports and documents which outline the status of Concurrent Employment. The QA report presented on the 1 March 2024 states that the policies and practices which underpin the solution have not yet been settled. A DXC deliverable (ID18 and CR123) has been approved by the Department which sets out how DOH's requirements will be met. This disconnect is concerning as the sign off of the DXC deliverable suggests Concurrent Employment is ready for Build and related implementation activities. Based on the status of the project there will be schedule and cost impacts as updated to existing design documents and Implementation activities will need to be undertaken. Our assessment of Concurrent Employment is consistent with our opinion on the KDD's which have been "kick down the road" and as a consequence there will be an impact the timeline and costs.

3.7 Change Management and Training — Risk Rating - Extreme

a) **Change Management and Communications** stream of the Program has not been able to develop appropriate Change Management strategies, Training strategies and Change Impact assessments. These deliverables should be an output of Enterprise Design however, they are yet to be produced and consequently the Program has not been able to effectively communicate with the business.

b) Change Management is an **integral component of the Program** and as such, the overall Program work plan and SOW's need to be tightly integrated. This is not the case and as a consequence the dependencies between the technology, Business readiness and CMT streams are not clear.

c) The Program needs to be **managed wholistically** and not as separated projects given the relationship between each.

4. Assessment of Program Risk and Issues Register

The scope of this review included an assessment of the adequacy of mitigation strategies of the known risks, propose any additional strategies for consideration; and Propose mitigation strategies for the discovered/unknown risks**.**

The Program has a risk and issues register which sets out the known risks and issues with the impacts, mitigation strategies, rating and owner. The Risk and Issues register is maintained by the PMO with regular updates by stream leads.

Risks are separated into the following categories, Strategic, Operational and HRIS. The segregation into these categories is inconsistent with ERP led transformation projects, where all three categories are related which includes the treatment of risks. As such, the impacts are not adequately expressed and the mitigation strategies are limited to the scope of each category.

In many cases the Risk and Issue register is silent on the root cause. For example, RO-0078:

Description	Consequence	Mitigation strategy
There is a risk that the Service Delivery Model will not be adequately defined in time to perform UAT for Systems Support roles.	The consequences of this risk are: - System Support team are not well trained in the system to provide support on Go Live - Testing of System Admin roles permissions within the Department will not be adequately tested	Reduce the likelihood

The root cause of this risk is that the operating model was not defined in Enterprise Design:

- *Consequence.* The design, build and testing phases have been comprised and rework is required address the gap.
- *Mitigation Strategy*. Revisit this KDD and assess the associated impacts and provide management with options to reduce the impact on time, quality and costs.

Our assessment of the Risks and Issues register highlights a level of inexperience in the team to identify key risks and recommend suitable mitigation strategies. Furthermore, it is apparent that whilst the team has a perspective of the risks and issues they are not able to take the appropriate action or effectively communicate the matter to senior management for consideration.

The management of the risk and issue register seems to lack involvement from the SI which is inconsistent with best practice. It is notable none of the risks and issues highlighted by the DXC Program Director are listed. The management of risks and issues is a joint (SI and Client) responsibility including the attendance at RAID meetings and escalation forums.

As part of the proposed program reset the risk and issues register needs to updated supported by the appropriate governance model.

5. Recommendations

Generally, the root cause of troubled ERP led transformation programs relates to how they were conceived. Many of the findings of this review relate to how the program was poorly established. This includes the inability of the Department to address key design decisions in Enterprise Design which has contaminated the subsequent phases of the program and led to an incomplete solution.

The role of the Systems Integrator is to not only execute its tasks but to guide and coach the organization through the overall program. DXC have not been able to deliver upon these fundamental obligations and have overseen a Program of work which should have been halted in Enterprise Design, to ensure fundamental design decisions were addressed. Going forward the suitability of DXC needs to be evaluated and alternatives considered.

The Departments Program team lacks the required business resources and their insights. This issue has impact the Design, Build, Change Management, Business readiness and Data. Going forward the Department must address the lack of business expertise and assign its best people to the project on a full-time basis.

The overall governance of the program is not effective and must be addressed in the proposed planning phase. The current structure lacks many of the critical elements of a well-functioning Program, including a business process owners forum to help inform the steering committee of program recommendations and decisions. Another significant gap in the Program is the absence of a experienced project manager. This is a key role and must be sourced in the planning phase.

Management of the Programs financials requires a greater level of rigor. The findings of this review highlight the likelihood of the costs of the program significant exceeding budget. Locking down scope, assumptions, dependencies and the required resources will help address this issue as these aspects are poorly defined.

It is evident there are too many outstanding fundamental issues for the Program to continue in its current form. As such, we recommend the Program refocuses its efforts to address the issues outlined in this report by developing a revised plan and approach and once approved this be implemented before moving any further into the Program.

6. Next Steps

In terms of the next steps we recommend a structured planning approach is undertaken with the objective of addressing the findings of this review. The following is a high-level plan to support the re-planning of the Program:

	Resources	5-Apr	8-Apr	15-Apr	22-Apr	29-Apr	6-May	13-May	20-May	27-May	3-Jun	10-Jun	17-Jun	23-Jun	30-Oct
Phase 1															
SC Approval	SC														
Program Communications	PD, Comms Lead														
Prepare comms															
DOH	PD, Comms Lead														
Vendors	PD, Comms Lead														
Team assignment to roles	PD														
Gaps Assessment	All														
Stock Take	All														
DXC Agreements	DXC, DOH, KLgates														
SOW 3a Completion	DXC, DOH, KLgates														
CMT	DXC, DOH, KLgates														
Project Communications	Comms Lead														
Resources	PD														
Financial Update	PD Financial Analyst														
Governance	PD														
Phase 2															
Sourcing Strategy	PD and KLGates														
SI Brief	PD, DOH and KLGates														
SI Engagement	PD and KLGates														
Project Communications	Program Comms Lead														
Financial Update	PD, Financial Analyst														
Resources	PD														
Phase 3															
SI RFP	PD and KLGates														
Update Business case	PD														
costs	PD, Financial Analyst														
benefits	PD, Financial Analyst														
risks	PD, Financial Analyst														
Resources	PD, Financial Analyst														
Governance	PD														

Summary of Phases and Key Activities

Phase 1. 5 April – 3 May 2024

Scope:

The scope of this phase is to address the findings of the HRIS review including the preparation of a detailed plan, approach, resources, and costs to support Phase 2 and 3. The output of this Phase will be presented to the Steering Committee for approval before progressing to the subsequent phases.

Key Activities:

1. SC Approval
   SC endorsement of the HRIS findings and plan.

2. Communications
   - Preparation of communications to the following stakeholder groups; Department, Program Resources and Vendors (DXC, Attura, SAP and UKG) to inform them of the status of the Program.
   - The assignment of tasks and deliverables to Program Team.

3. Gap Assessment.
   Based on the findings of the HRIS review and "stock take" prepare a list of gaps in the current solution. Note, many of these gaps relate to Enterprise Design.

4. Project Stock Take
   Project "stock take" which includes a high-level assessment of project artefacts to determine their value to the program going forward.

5. Vendor Contracts.
   a. DXC.
      i. Specify the work required to complete SOW 3a and related Department resources to support the completion.
      ii. Assess the value and relevance of the work to be completed.
      iii. The Payment of the final invoice is be determined based on work delivered and any associated delays which may attract Liquidated damages.
      iv. Change Management and Training SOW. Assessment the status of this work and relevance to the forward plan.
   b. SAP and UKG
      i. Assess the impact of extended pause and go live date.

6. Project Communications.
   Based on the work completed in this phase, prepare a communications plan and activities to address the stakeholders impacted.

7. Resources
    a. All current Department resources engaged on the Project will be required for Phase 1. Exceptions include, Deployment and Benefits Lead, Test Lead and Program Scheduler. These resources will not be required for Phase 1 and future phases.
    b. Skills required to support Phase 2 and 3 and potentially the Implementation phase. Assessment of the current teams skills against the required skills.
    c. At the completion Phase 1 it is anticipated that some existing Program resources will not be required. Consideration of their employment/contract arranges will be assessed.
    d. On boarding of a dedicated financial analyst is required to support Phase 2 and 3.

8. Financial update.
    a. Costs to complete the planning phase (Phase 2 and 3)
    b. Assumptions and dependencies.

9. Governance
    a. Preparation of a governance structure to support the planning phase, including.
        i. Governance groups and terms of reference.
        ii. Skills required.
        iii. Decision making framework.
    b. Risk and Issues register and process to be reviewed including actions to remedy current practices and registers.

Phase 2. 6 May – 28 June 2024

Scope:

Program business planning and SI early engagement.

- Confirm objectives and scope of the Program with key stakeholders.
- Prepare a list of alternative SI's (likely DXC, Deloitte and Accenture) with required skills to support the completion of the Program. High priority skills include, business transformation in the health industry, visioning to support future state operating model, technology skills to support the preparation of the solution, change management and training and the ability to leverage global capabilities to guide the Department.
- Prepare a brief for the SI market based on existing artifacts, renewed objectives, Department resources (to be confirmed in this phase).
- Preparation of a sourcing strategy to select a SI.
- Confirmation of resources to support this phase.
- Prepare a detailed plan for Phase 3
- Update of the financials based on the detailed plan for Phase 3.
- The output of this Phase will be presented to the Steering Committee for approval before progressing to the subsequent phases.

Phase 3. 1 July – 30 October

Scope:

The scope of phase 3 is to execute the sourcing strategy with the objective of selecting a suitable SI to support the Program. This phase would also deliver.

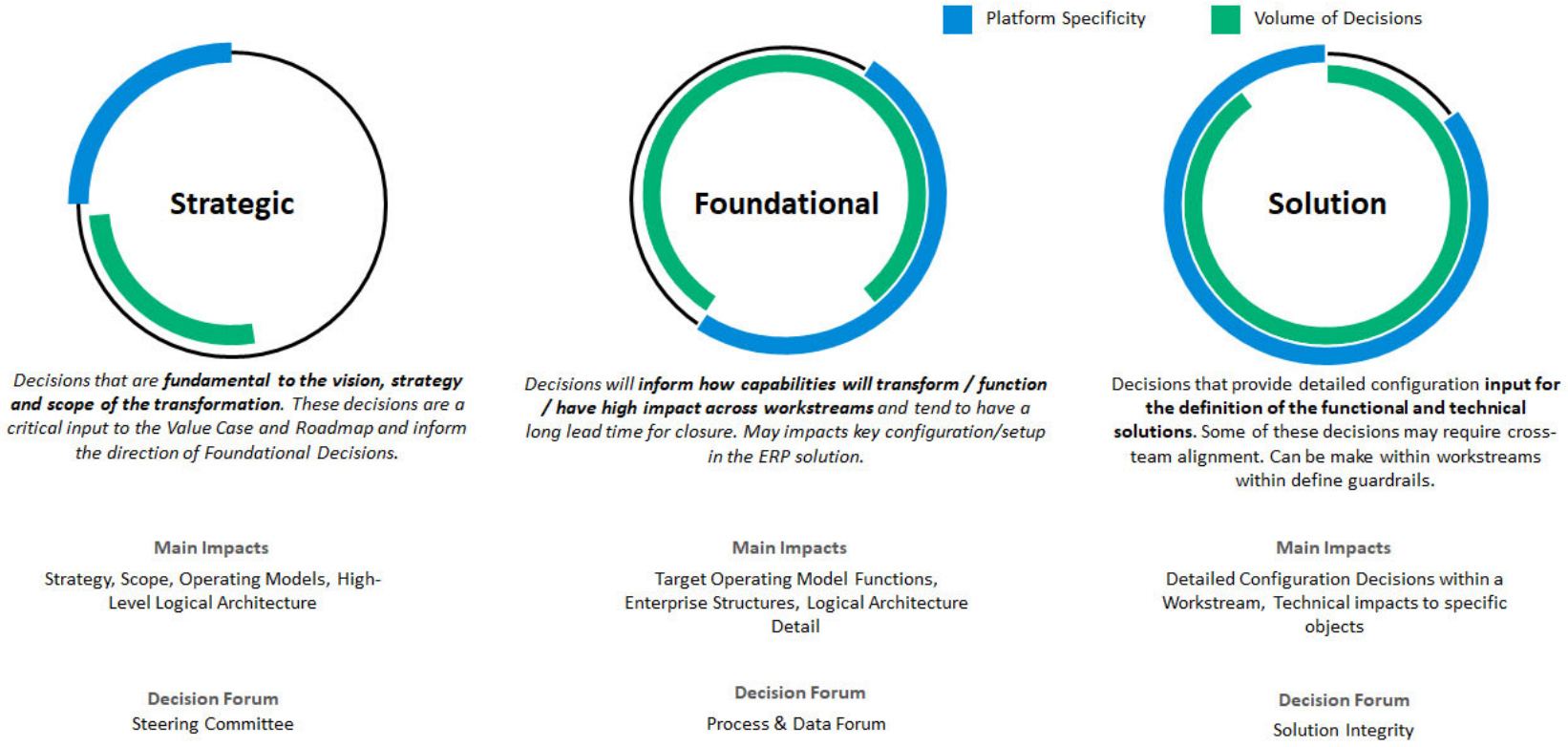
- Updated business case including costs and benefits.
- Governance structure to support the Implementation phase.
- Assignment of senior business resources into the project.
- Vendor contracts to support the implementation.
- Recruit internal and external resources to support the Implementation.
- The output of this Phase will be presented to the Steering Committee for approval before progressing to the subsequent phases.

Appendix A - Interviews

	Name	Role
1	Shane Gregory	Sponsor
2	Michelle Searle	CPO
3	Brent Feike	CIO
4	Penny Ratcliffe	Program Director
5	James Booker	Benefits and Deployment
6	Scott Parnham	Program Manager
7	Andrew McArthur	Technical Solution Lead
8	Maree Critchley	Business Lead
9	Tina Psereckis	Rostering Lead
10	Quecha Horning	Change Management
11	Elmo Jones	Testing
12	Matt Wilson	PMO
13	Phillip Hood	QA
14	Ashley Brooks	Rostering Best Practice
15	Paul Simon	Program Scheduler
16	Areum Kim-Lee	DXC Program Director

Appendix B - Example Decision-driven framework

The Program needs to consider the strategic and foundational decisions that were not adequately addressed in the early stages of the Program:



Appendix C - Example - ERP Decision Authority Matrix for agile decision making

The following matrix provides an overview of the decision-making authority that will govern the ERP Programme across the key areas of: Scope, Solution & Benefits, Schedule and Budget:

Decision Area	Steer Co	Project Sponsors	Data & Process Owners Group	Solution Governance Group	Project Control Group	Change Control Group	Group Security
Members			*Process Owners Project Director Business Lead*	*Lead architect Project Director Project Leadership Technical Leads Function Stream Leads*	*Project Director Project Leadership ERP lead architect*		*Digital Security Manager*
Scope / Schedule / Budget Change							
Change to baseline scope (No impact schedule/cost/solution/benefits)			I	I	I	A	
Changes in baseline scope (Impact to schedule/cost) over $2m	A	C	R	C	I	C	
Changes in baseline scope (Impact to schedule/cost) below $2m	I	C	R	I	I	A	
Change impact on project schedule and deadline. Contingency will be used	I	A	R	C	C	C	
Change impact on project schedule and deadline over Budget. Request for additional budget	A	C	R	C	C	C	
Solution & Benefits							
Change to Solution/Configuration that has minor impacts on benefits			R	R	I	A	
Change to Solution/Configuration that has a significant impact on benefits	A	C	R	R	I	C	
Any Customisation	A	C	R	R	I		
Change to Solution/Configuration that has Cyber Security implication			I	R	I	R	A
Change to Solution/Configuration that has impact on Enterprise Architecture			I	R	I	R	
Changes to Key Resources							
Change impact on stream Key resources Adding / Removing		A	R		I		