Thursday 8 June 2017 - Estimates Committee A (Ferguson)

LEGISLATIVE COUNCIL

ESTIMATES COMMITTEE A

Thursday 8 June 2017

MEMBERS

Mr Armstrong
Mr Farrell
Ms Forrest (Deputy Chair)
Mr Gaffney
Mr Hall (Chair)
Mr Valentine

IN ATTENDANCE

Hon. Michael Ferguson MP, Minister Health, Minister for Information Technology and Innovation

Ministerial Staff

Peter Poggioli, Chief of Staff
Kyle Lowe, Adviser
Chris Edwards, Adviser
Bree Groves, Adviser

Department of Health and Human Services

Michael Pervan, Secretary, Department of Health and Human Services
Michael Reynolds, Acting Deputy Secretary, Corporate Policy and Regulation Services
Ross Smith, Deputy Secretary, Purchasing, Planning and Performance

Dr David Alcorn, Chief Executive Officer, Tasmanian Health Service
Nicola Dymond, Chief Operating Officer, THS
Craig Watson, Chief Financial Officer, THS

Neil Kirby, Chief Executive Officer, Ambulance Tasmania

Mark Veitch, Acting Director, Public Health Services, DHHS
Peter Boyles, Chief Pharmacist, DHHS

Ben Moloney, Project Director, Royal Hobart Hospital Redevelopment

Department of Premier and Cabinet

Ruth McArdle, Deputy Secretary
John Willson, A/Director, Office of eGovernment
David Briggs, A/General Manager, TMD
Robert Cockerell, Manager TMD Future Directions, TMD
Katie Ault, Commercial Strategy Manager ,TMD
David Strong, A/Director, Corporate and Culture Division
Andrea Ramondino, A/Director Finance

Department of State Growth - ICT and Innovation

Bob Rutherford, Deputy Secretary Industry and Business Development
John Perry, Coordinator General
Mark Bowles, General Manager Client Services
Stuart Hollingsworth, Director Policy & Programs, Workforce Development Systems
Amanda Russell, Deputy Secretary Business Services **OR**
Glen Dean, Finance Director

The Committee met at 9.00 a.m.

DIVISION 3
(Department of Health and Human Services)

Minister for Health

DEPUTY CHAIR (Ms Forrest) - Thank you, minister for joining us and your team. Our Chair is absent for this morning. He may be here later today, so in the absence you will putting up with the rest of us. If you would like to introduce your team at the table for the benefit of Hansard, we will get started.

Mr FERGUSON - Thank you, Chair. I introduce Mr Michael Pervan to my right, Secretary of the Department of Health and Human Services, Mr Michael Reynolds, Acting Deputy Secretary, Corporate Policy and Regulation Services, Ms Eleanor Patterson, Chief Financial Officer, and to my left, Mr Ross Smith, Deputy Secretary, Purchasing, Planning and Performance Department.

DEPUTY CHAIR - I assume you would like to make some opening statements.

Mr FERGUSON - I will just be brief and make some introductory comments, Madam Chair, making it very clear that the Government's focus in the health portfolio is on Tasmanians and what our state needs ensuring that we maximise our ability to give Tasmanians the health services that they need and deserve. We have spoken many times at this committee about the work that the Government has been undertaking through the One Health System improvement, taking the regional structures and bringing our state health policy together as one state. To that end, the White Paper has been a very significant vehicle for designing safer services, ensuring that every hospital in our state has a clear and defined role, but importantly, services that are designed to be safer. The redevelopment of the Royal Hobart Hospital is a very important project for us and we are very pleased that the project itself is on track and we look forward to that being part of the long-term

solution to some of the challenges that we are all aware of at the Royal, particularly with patient access and bed flow and bed access.

Elective surgery has been a fantastic achievement by the Government working together with management and our frontline staff. We thank them all for their contributions and we are very pleased that record numbers of Tasmanians have now received their surgeries and as a result of which we are able to point to the record low waiting list. We are as a government very aware of the reality of growing demand in the health system, well, growing demand for Tasmanians to receive health care which has an impact on our hospitals. We are, of course, aware as well at the Royal where are redeveloping a working hospital, so there are physical constraints on our capacity to open additional beds, but nonetheless, we are doing that, and I am pleased to advise this committee that the final batch of 10 beds as part of our 27 additional beds for the Royal or at least for Southern Tasmania at the Roy Fagan Centre are now operational with the additional recruitments now occurring having had occurred and those additional 10 beds being opened.

There is a big effort to implement the total of 106 beds which are funded in this budget. That is a big task and earlier this week I did outline some steps that the Government is taking to get the very best from a team whole of government approach opening those beds with the department working with the Tasmanian Health Service. That is the Department of Health and Human Services working with THS and additional resource through DPAC so that we can have the best implementation of that and in a timely way.

Ambulance Tasmania is also part of our health system which is experiencing that increased demand. We are seeing record numbers of Tasmanians calling on our ambulance service for care and our priority is to make sure that we continue to meet the emergency challenge there and ensure that we receive - Tasmanians receive earliest possible arrival of a paramedic team when it is an emergency call. We have released the Government's review into Ambulance Tasmania and we may well explore that later today. But the first thing that the Government has done in receiving that report is to acknowledge it and to fund two new crews, one in the north, one in the south.

The Government is pleased with the progress that is being made in the One Health System reforms, but we recognise that the job is not done. There is growing demand and we want to meet that and the budget, while providing significant extra funds for health, the largest ever single boost to the health system in the state's history, our challenge as a health manager now is to implement and see those improvements and that additional capacity come online. To that end, as I say, we need to all work together to see those things occur.

DEPUTY CHAIR - Thanks, minister. What we intend to do is do some overview questions and then do output group 1.1 and then 2.1 which then will take us to budget paper number 2 with Tasmanian Health Services and go down into that area more thoroughly just to make sure you have got the right people around.

Mr FERGUSON - Yes, and to assist you, what I have planned is that when we get to 2.1, I will have THS executives at the table as well.

DEPUTY CHAIR - Thank you. I would like to try to clear up a bit of misunderstanding out there about the level of spending on health. The table, if you go to budget paper number 1, page 177, it indicates spending on health in 2017-18 will be $10 million more than the estimated outcome for 2016-17, with a further $10 million in 2018-19. My question is, do these figures include the $20 million provision account in Finance General in both years?

Mr FERGUSON - What I am immediately going to do here, Deputy Chair, being aware of some of the different things that have been said is invite the Secretary and the Deputy Secretary, Mr Reynolds, to assist with the interpretation of budget figures. There is an important component of funding provided through Finance General which hasn't always been referred to in some of the public commentary.

Mr REYNOLDS - The short answer is no. We understand these are Treasury derived figures using the uniform presentational framework and we are advised that the $20 million hasn't been reflected in the health expenditure line at this time.

DEPUTY CHAIR - Where is it reflected?

Mr REYNOLDS - That is a good question. I am not entirely sure where they have put it. It may be under the 'Other purposes' category, but I would have to check with my Treasury colleagues to seek that information for you.

DEPUTY CHAIR - I did try to drill down into this with the Treasurer and we seemed to be doing the roundabout roundabout thing here again. People have this expectation out there that a lot more money has been put into health and maybe it is, maybe it isn't - it is really hard to tell. It may be from the previous year's budget, but from the last year's estimated outcomes, this current year we are in, it would seem that is not necessarily the case. It would be interesting to know where this $20 million actually is. You are saying through your minister, Michael, that the budget figures for health on page 177 contain the $20 million for the provision in Finance General?

Mr REYNOLDS - That is what we are advised of, yes.

CHAIR - That is additional?

Mr REYNOLDS - Additional. That is exactly right.

DEPUTY CHAIR - Minister, can you then perhaps explain to me the circumstances that explain the creation of the $20 million provision in Finance General? The Treasurer had some comment. Unfortunately, I haven't been able - our *Hansard* of the Treasurer is not available as yet, but I did make note of what he said. I am interested in your understanding of how that happened.

Mr FERGUSON - I will be very careful to not step into the Treasurer's portfolio in answering this, but the structure of the Budget and the way in which the numbers are reported according to Australian Accounting Standards is definitely a matter for the Treasurer. But I am aware because I have been part of the budget process that the funding has been especially - $100 million has been especially allocated to health through the financial general chapter.

Ms FORREST - $100 million?

Mr FERGUSON - Yes, that is right., 20, 20, 30, 30. With regard to the inclusion of health funding through Finance General, I am advised that this is not unusual. It is a sensible, prudent budget management measure and, indeed, many important government initiatives have been and are funded through Finance General. It is one of the final aspects of the Budget to be locked down and there is a relevance here to the timing of the federal budget and also, importantly, the confirmation to the state of our share of GST funding which is only available in early May. The

Government made a calculated decision to ensure that we were able to maximise our expenditure in health in this budget and this is the mechanism by which the Treasury and the Treasurer through the budget process have opted to do that. But that has had an implication for the reading for some members of the community who may not be aware of that for understanding the actual estimated - the actual expenditure through THS in the THS chapter because it sits in addition to the Finance General funding.

Mr REYNOLDS - Minister, if I may clarify, while we have been having that conversation, I have received some further advice. The $20 million for the Finance General, not, it is not.

DEPUTY CHAIR - For the what, sorry?

Mr REYNOLDS - The money that is allocated in Finance General obviously isn't reflected in the departmental chapter's expenditure. I am advised that it is reflected in table A1.17, health.

DEPUTY CHAIR - Yes, 177.

Mr REYNOLDS - The full health expenditure which then equates to the $7.1 billion in record health spending for this sector is reflected in those particular numbers.

DEPUTY CHAIR - The Treasurer did make comment that he was waiting on news of the federal budget and that he received the news on the Friday before. You receive news on the Friday before the federal government received the news on the Friday before the budget about, I assume it would be grants that would be coming from the feds. What was the news? Was it more money coming or less money coming?

Mr FERGUSON – Deputy Chair, with respect, that is a question that only the Treasurer would be best able to answer. It is not within my advice at this table now to give that answer. But, yes, there was more money that we received and we front-lined that into health.

DEPUTY CHAIR - To move on, I thank you for providing two of the four answers to the questions without notice I provided 10 days ago. They were questions all related to health and the health budget. I request now that you also provide the answers to the other two questions related to the estimated outcomes of the THS and the parameter changes related to the DHHS. When I received the answers to the - and I will come back to that in a moment - the answers I did receive last night, I thought they certainly did not contain much information that was of assistance. In fact, it was almost a bit of an insult or disgrace in some respects. This pusillanimous approach is intended to confuse rather than assist because they don't actually explain anything about what is being spent in the output group. When we get to output group 1, I will explore that further. Can you now provide the other two answers because that is really important that we have that before we start into the THS because it is the estimated outcomes for all the output groups in the THS.

Mr FERGUSON - With great respect, I don't have that information with me. The information that I did provide in good faith last evening to you directly was to assist you as much as I possibly could. They were questions that were laid down in the Legislative Council and to be as helpful as I could be, I wanted to ensure that the answers that were provided to you, that I was able to, were provided to you yesterday before today's hearing. As soon as I am able to provide you with the other answers, I will immediately do that together with as much explanation as I am also able to provide.

DEPUTY CHAIR - When can we expected the estimated outcomes for the THS? We are dealing with that very soon.

Mr FERGUSON - The Budget provides and the Treasury put forward all of the structure of the Budget and if there is further more detailed answers that you are seeking, I will provide you my best endeavours to give you the answers. There shouldn't be any suggestion that it is an attempt to confuse, or whatever other word was used, to frustrate your wish to understand this more.

DEPUTY CHAIR - When I asked the Treasurer some of the questions in other areas, he has provided that. Treasury did say that it is clear this information is available and hopefully they are expecting under the new budget reporting system and the new schmicko system as I called it, which they quite liked, that will come online next year, that it will actually provide all these level of reporting. It is impossible to understand the growth expenditure in an agency within a line item if you are only looking at last year's budget. The budget is the budget. It is not the spend. The estimated outcome gives a pretty clear indication of what the spend is and then we can move to look at how much more in this area. It seems to me the additional funding is more in the DHHS output groups, not in the THS. Without that information, I can't be sure.

Mr FERGUSON - I can only point you here to the budget papers. If you were looking at the deliverables elements of both Department of Health and Human Services, the THS chapter and the capital elements of both chapters, you do rapidly see the larger funding that the Government is providing, you cannot open 100 and permanently fund these additional 106 beds. You cannot do that on less funding. It can't be done. I appreciate the point that you are making, but the Government is providing real additional funding and it is being expressed and reported through the way that Treasury reports all the numbers that shows the total expenditure in health over four years reaches $7.1 billion.

DEPUTY CHAIR - I am hoping to look at that information before we get into the THS, otherwise it makes it very difficult.

Mr FERGUSON - I cannot undertake to give you that right now. I don't have it, but as soon as I do, it will be provided to you. I will attempt to have it to you at the earliest opportunity.

DEPUTY CHAIR - Minister, how much of this extra funding will the THS get and how much in dollar terms? How much does the departments in the DHHS, the two areas in DHHS that we are dealing with - sorry, there are three areas in DHHS.

Mr REYNOLDS - We don't neatly have the information that shows between the department and the THS the budget allocation in that sense, but we can seek to.

Mr FERGUSON - Because it all washes through the department.

Mr REYNOLDS - I can assure you, though, that the bulk of the funding is actually going through to the THS.

Mr FERGUSON - Can you please explain for the committee how the department is provided with the funds and how it is then used as purchasing and how Finance General rolls into that as well.

Mr REYNOLDS - Certainly. The funding that we are receiving for those initiatives that are directly related to the THS will be provided through to the THS through the purchasing arrangements that we have. Those initiatives that are specifically related to the department, for example, some of the mental health ones or the ambulance initiatives, for example, they will stay with the DHHS. But those initiatives that are specifically health service related, THS related, are provided through their allocation, through the purchasing arrangements. They don't receive a direct appropriation as a department, as we do, but through the purchasing agreement and service agreement that we have with them, the initiatives that the Government has undertaken to implement this year and through the forward estimates, but this year in particular will be reflected in the service agreement and the funding associated with that.

Mr FERGUSON - And the Finance General funding.

Mr REYNOLDS - And the Finance General funding will ultimately flow through and that will be reflected ultimately in the service agreement as well.

DEPUTY CHAIR - How will we see that? I am hoping that next year's budget papers are going to be a lot better in this regard. The Treasurer gave that indication that they would be, so hopefully they will be. You can understand the scepticism out there when people are waiting for surgery or seeing ambulances ramped and finding challenges with accessing the health system themselves. Whilst you hear many good stories too, the ones you hear more about are the ones that aren't working so well by the very nature of that.

Mr FERGUSON - That is right. We understand that.

DEPUTY CHAIR - I accept that. Yes, people find it easier to complain than to give commendation. But how will people like us and the general public be able to see how this money flows through?

Mr FERGUSON - I might make a comment there and, again, Mr Reynolds whose previous role and substantive current role is the chief financial officer in the department so he -

DEPUTY CHAIR - He came out of Treasury.

Mr REYNOLDS - That is right.

Mr FERGUSON - He is our numbers guy.

DEPUTY CHAIR - I used to sit across the table from Treasury at one stage.

Mr FERGUSON - Indeed. I understand the points that you are making and we completely respect Tasmanians who have felt let down by or who are frustrated by waiting for their health services. The Government has made some very specific policy decisions to increase health service delivery. They are specifically named and funded, as I am sure you would be well aware, and in terms of the way that the Treasury structured the reporting of the Budget, obviously, that meets the necessary standards. But I don't want to make a fine point about this. It is important. It is a pivotal point. The Government has prioritised significant additional funding into health. The focus on Finance General is not a point of contention for me at all. I am not concerned about that. I do understand that allocating $100 million through Finance General means a more meticulous reading

of the Budget is needed to be able to fully capture all of the funding and the way that it will be delivered.

DEPUTY CHAIR - We need to see it flow to health, minister, because that is the question.

Mr FERGUSON - I understand.

DEPUTY CHAIR - While it is sitting there, in theory, it could be taken elsewhere.

Mr FERGUSON - Yes, but with respect, it is not in theory. The money is there and it is being -

DEPUTY CHAIR - I am not saying the money is not there. I am saying where it could go to.

Mr FERGUSON - It has been specifically earmarked for health services which are all named up. For example, the 106 additional beds is one of the many measures and they are there as budget deliverables and they are reported with policy and parameter statement descriptions. I do respect and understand the wish to get full literacy on a reading of the Budget. As a Government, we assure Tasmanians that it has met all of the necessary accounting standards. But the fact that the funding - the fact that some of the funding for health has been progressed through Finance General is, in fact, good news because it has demonstrated that the government had made a deliberate decision to focus as much of the additional GST revenue which is reported quite late in the budget process and that is, in fact, the way that Treasury wanted and the Treasurer and the cabinet wanted to ensure that we had that additional gain in revenue to then be able to be prioritised to the health portfolio. That is vehicle that has been used to achieve that outcome. It is actually a demonstration that we did need to wait for the final GST figures to know exactly how much additional funding we were able to put into the health portfolio over and above known state revenues. Maybe I have answered it for you.

Mr REYNOLDS - You have, indeed, minister. Coming back to your earlier question, Ms Forrest -

Mr FERGUSON - Have I done as good a job as you would have done?

DEPUTY CHAIR - No, don't get too excited.

Mr FERGUSON - No, I wouldn't, but that is the Government's approach on this.

Mr REYNOLDS - I am very confident that the money will flow through to the Department of Health and, ultimately, the THS. It is going to be factored into their spending and their particular initiatives this year. I imagine that Treasury will have a mechanism later on in the financial year to transfer that across to -

DEPUTY CHAIR - It should be. Under current public accounting practice, it should be under section 19. I imagine, that is where it will come from.

Mr REYNOLDS - That is it. There are a number of mechanisms that they can do that and that may be one of them. So, there will be clear visibility from a scrutiny perspective of the money going from Finance General to the Department of Health and ultimately through to the THS.

DEPUTY CHAIR - Don't worry. Now I am back here for six years, I will be watching you.

Mr FERGUSON - Yes, but please don't get me wrong. From a communicating with the public point of view, I would have loved to have seen all of the funding coming through Finance General, the $100 million, more easily identified by the public for THS and health expenditure lines because it has been misread by a number of people and widely misreported. Well, not correctly -

DEPUTY CHAIR - No, it is not misreported because if you look at the numbers -

Mr FERGUSON - Correctly reported of a misunderstanding by some people in the Tasmanian community trying to suggest that there is actually less money in the Budget for health which is completely untrue.

DEPUTY CHAIR - In all fairness to the general public, minister, most of them would read budget paper number 2 and volume 2, looking at the THS, there is only a few tragic individuals like myself who read budget paper number 1 from cover to cover, and there are a few others I know who did so around the table.

Mr FERGUSON - I would say, if I may, with respect, very few Tasmanians would have read any of the budget papers, but would be looking for the actual new commitments that are being made. But page 59 of budget paper 1 very clearly points out the additional $100 million that a number of Tasmanians had not identified including some of our political opponents had not identified as being there when I was -

DEPUTY CHAIR - Page 59 of?

Mr FERGUSON - Of budget paper 1. In public media interviews, I was being asked to explain the false allegation that there is less money for health which is patently incorrect, but it is a matter that those individuals overlooked page 59 of budget paper 1 which very clearly shows $100 million of extra health under the line item 'Health funding provision'. Lots of people approached this in good faith. I am certainly one of those. The focus for me as Health minister is, of course, to see the policy decisions made by government are actually implemented. The extra ambulance crews, the extra beds, the extra mental health packages. I am going to ask the secretary to add to this answer.

Mr PERVAN - Navigating the budget papers is always fraught not just in Tasmania but anywhere for members of the community who are interested in the dollars that actually flow through to the THS. In 22 days we have to have the service agreement up and running. The act requires that to be agreed or otherwise promulgated from 1 July and then we put that on the internet as soon as the minister and the chair and the governor-in-council have signed it. It is also tabled in parliament and that contains all the details of the money that flows through the department and other sources into the THS. It is very public and easily accessible source of all the information rather than having to navigate through the budget papers. That will be there in three weeks.

DEPUTY CHAIR - Our job is to scrutinise the Budget through the budget papers.

Mr PERVAN - I appreciate that. I was trying to assist the community.

DEPUTY CHAIR - Page 59 of budget paper number 1 has a footnote 10. Footnote 10 says: 'For further information on the policy, refer to the Department of Health and Human Services chapter in government services budget paper number 2'. Yes, you can go there, but it doesn't tell

you how that money is moving. So, that is a road to nowhere. That is why I am trying to track the money, trying to chase the money, and verify the claim that this extra money is going there. We have gone through but there is a footnote there but it says, 'More information there', but you can't actually find the information that you require to demonstrate that. Hence, the frustration. It is not just to myself, but of others as well. The media was as confused as everyone else.

Mr FERGUSON - I don't proclaim any expertise in accounting standards, but if I can also point you to the Health and Human Services chapter, table 4.1, which outlines the key deliverables. That would come as a welcome set of statements about the way that significant additional funding is actually going to be delivered in real outcomes.

DEPUTY CHAIR - Yes, but what I am saying is that it is impossible to track that particular money.

Mr FERGUSON - When I went through my budget chapter here, I personally have a particular way of tracking things and I noted footnote number 10 under table 4.1, any line item out of footnote number 10 is identified as funding for this initiative is allocated within Finance General. When I went through my list, I identified John L Grove, the LGH ward 4D boost, the One Health System new services, the Repatriation Hospital capital, the Royal Hobart and Repatriation Hospital support package, the statewide operations and command centre. They are the ones that I identified from that footnote. Hopefully that answers your second previous question about how Tasmanians could see that the funding provided through Finance General actually materialises into some outcomes.

DEPUTY CHAIR - I don't disagree with you there but a lot of these, like Patients First, which don't have a footnote 10, for example, they are the things that are delivered to the THS.

Mr FERGUSON - They are all delivered.

DEPUTY CHAIR - Not all of them.

Mr FERGUSON - Well, many of the - even many of the -

DEPUTY CHAIR - But they are.

Mr FERGUSON - Yes.

DEPUTY CHAIR - The ones with the five are delivered by the THS.

Mr FERGUSON - Correct.

DEPUTY CHAIR - Yes.

Mr FERGUSON - But even many of the ones that I identified as funding provided through Finance General are also delivered by THS.

DEPUTY CHAIR - Also, yes.

Mr FERGUSON - But their funding has come through two different ways. If I can assist you and the committee in any other way, I am happy to take any questions of that nature on notice, not just responding as I am obliged to and want to through the Legislative Council process, which you

have already tabled a number of questions. If there are further questions I can take on notice, that of course obliges me to respond to the committee, and I am happy to take those forward.

DEPUTY CHAIR - I have a couple more on overview. Does anyone else want to do any on overview at this stage?

Mr VALENTINE - And to do with ICT. Is that an overview sort of question?

DEPUTY CHAIR - I guess it is, yes.

Mr VALENTINE - I am interested –

Mr FERGUSON - Mr Valentine, may I just make one other quick comment?

Mr VALENTINE - Yes.

Mr FERGUSON – Deputy Chair, you did earlier mention that you had placed four questions on notice. I thought there were three and so we may just need to communicate and ensure we have your full list of four.

DEPUTY CHAIR - Yes.

Mr FERGUSON - I just wanted to get that on the record.

DEPUTY CHAIR - That is all right. Who should I hand it to?

Mr FERGUSON - We could look at that during the morning.

DEPUTY CHAIR - So ICT related to Health, you're talking about?

Mr VALENTINE - It is to do with Health, basically DHHS, but I suppose that supports THS as well at the end of the day.

DEPUTY CHAIR - Yes, that's right, yes.

Mr VALENTINE - So is that all right to do that here? I note in the budget that you have $18 million for Digital Transformation Priority Expenditure and that's part of - is that part of the $50 million that's going forward in the estimates that indeed is being put aside for the ICT Priority Infrastructure Program?

Mr PERVAN - That is right, I believe.

Mr VALENTINE - I wanted to clarify that they were not two separate things, the way it reads. Can you tell me what those critical systems are that are being focussed on, and obviously they are not totally designed and cannot be delivered just yet, but are you able to sort of expand on that?

Mr FERGUSON - The answer to the question is, yes, it is funded through the $50 million. That was identified, in fact taken as some of the special grants as well. It is more than $60 million coming through whole of government IT projects.

Mr VALENTINE - Special grants coming from –

Mr FERGUSON - That is right, if you then take the two initiatives together that have been funded through Treasury, it is more than $60 million, but there is a $50 million, as you correctly stated in your question, the digital –

Mr VALENTINE - To clarify before we go any further, are you saying $10 million is coming from outside of State Government funding or that the state is putting an extra $10 million in?

Mr FERGUSON - An extra $10 million. There are two mechanisms by which Treasury has structured the digital transformation. One of those is the Digital Transformation Priority Expenditure Program, and that has had nominal earmarked $18 million for Health, and it's now the role of the Health Department to work through the Treasury Structured Infrastructure Investment Review Process.

Mr VALENTINE - SIIP or whatever it is, Structured Infrastructure Investment Review Process.

Mr FERGUSON - Yes, so the SIIRP process for short and convenience, to work up the business cases for the way in which those funds are going to be best - to best support the Health portfolio.

Mr VALENTINE - To clarify that, you are talking $50 million. You mentioned there was $18 million for Health.

Mr FERGUSON - Yes.

Mr VALENTINE - So are you saying the balance is for other things in the State Service?

Mr FERGUSON - That is correct.

Mr VALENTINE - So the $50 million is not all for Health going forward?

Mr FERGUSON - That is right. The $50 million, in fact as I say, the more than $60 million, I think $63 million is whole-of-government, of which Health has been earmarked $80 million.

Mr VALENTINE - Yes, all right. As long as we have got that clear. If you can just explain what those critical systems are that you are pursuing to obviously assist the whole system.

Mr FERGUSON - Of course. The budget provides the Department of Health and Human Services with $80 million through the Digital Transformation Priority Expenditure Program to address priority ICT investment, the Department has been undertaking a program of work to analyse risks within infrastructure and applications, and the outcome of this work will then determine where the money is invested. A priority investment area includes network security and the Department will work with other agencies to ensure investment is coordinated through a whole of Government approach. I have been briefed, and it's a confidential brief to me at this stage. I have been briefed on a range of areas where the Department has become aware of some significant vulnerabilities that we intend to address. That is being –

Mr VALENTINE - That are peculiar to Health?

Mr FERGUSON - Yes, they are.

Mr VALENTINE - As opposed to other departments?

Mr FERGUSON - Yes, they are.

Mr VALENTINE - Because we can deal with the other in the ICT section later in the day if you like. Quite clearly you don't want to be stating where those vulnerabilities are.

Mr FERGUSON - You are right.

Mr VALENTINE - I can understand that.

Mr FERGUSON - You are right, but we have undertaken a specific piece of work and taken some expert and bias which has given Government a very good view of some of the identified risks, and I can assure you as well, Mr Valentine, that we will not be waiting for the SIIRP process to be completed to fast-track some of the immediate, it has been called in some cases 'close the door' type actions, quickly and rapidly deal with some of the immediate risks that can and should be dealt with immediately.

Mr VALENTINE - I understand that.

Mr FERGUSON - That has happened, and is happening, and if you don't mind me not being too explicit about some of those -

Mr VALENTINE - No, I do not expect you to be.

Mr FERGUSON - I can assure you that some of those identified physical infrastructure risks were pretty significant and we want to patch them.

Mr VALENTINE - I can understand that, but the actual systems themselves that you are putting in place to actually support the Health Service, can you detail what those critical systems are?

DEPUTY CHAIR - The clinical are you talking about or the –

Mr VALENTINE - Yes, basically the information systems that support Health and Human Services, and the hospitals at the end of the day.

Mr FERGUSON - My Acting Deputy Secretary, Mr Reynolds, has been leading this work and he can provide some further advice.

Mr REYNOLDS - We are doing what you would perhaps describe as a root and branch review of all our systems. There have been some vulnerabilities identified in it, in both the physical sense and also application sense, and we have identified that we do need to put a significant amount of money into this area so the allocation of $18 million over the next four years is very welcome to the department and to the THS.

As you rightly point out, the symptoms cross lines, not only departmental, but also the THS space as well, of which there are a number of critical needs. As you understand fully, it is a 24/7 operation. We need to ensure we have a robust system in place that provides the infrastructure that these facilities require every day of the year, 24 hours a day, so we are working through in a comprehensive and systematic way to identify where those weaknesses are. As the minister has pointed out, we have already put in place some remedial actions to identify the more vulnerable issues and address those so we can rest a little easier, but there is more work to be done. We are lucky enough to have secured a new Chief Information Officer over the last few weeks and he is very experienced in this particular field and we are working through him to identify and develop a strategic plan to ensure where we have this money available we can invest it wisely and get the most from it. So it is a comprehensive review of our IT systems and applications.

Mr VALENTINE - I am well aware of the situation - I used to work obviously 20 years in Health in the ICT area, and I am well aware of the complexities and problems of that space. What I am interested in is seeing how you are actually progressing to an integrated system across the whole department, and especially the hospitals, because the transfer of patients from one hospital to another, the compatibility of systems, and all those things, so I would be very interested in hearing what those programs - and you do not have to give me the list here now, but if you can provide it - those critical systems that you are actually looking at implementing I would be very appreciative of that.

Mr FERGUSON - I can provide you some additional overview, and Mr Reynolds may also do the same. I can tell you that some of the things that have already happened and will still happen. To assist with data security, the department - by the way, the department manages IT for itself and for THS.

Mr VALENTINE - I know. I realise that.

Mr FERGUSON - Yes, just wanted to make sure the committee would know. To assist with data security the department maintains a scheduled back-up solution enabling recoverability of data and systems. This solution involve off-site back-up, providing additional security of the department and THS data, and something –

Mr VALENTINE - But basically redundancy.

Mr FERGUSON - Indeed, and I can tell you something that I wasn't able to tell you last year at Estimates, to improve the physical security which has been a known and outstanding ICT risk for many years. The department has migrated ICT systems out of the Department of Premier and Cabinet, TMD, Police Support Services Building Data Centre which we usually call Bathurst Street. This was finalised in March of this year as part of a major infrastructure stabilisation project. This has improved system availability, energy supply security and as you mention in your comment about redundancy, we now have dual data syndicated capability which we did not previously have. This has now occurred not just in the Health Portfolio but in wearing my ICT minister hat.

Mr VALENTINE - Cost to service.

Mr FERGUSON - It has happened across Government so it's been a major piece of work that's been led by DPAC and TMD and –

Mr VALENTINE - So there aren't any single points of failure in all of that obviously?

Mr FERGUSON - Happy to explore that later as well, but the architecture has been specifically designed so that we have fail over capability to a second site. To ensure energy security major hospitals have back-up generators to maintain the energy supply for life-support, operating theatres and essential systems, and a more resilient network design has also been implemented over the last financial year to deliver higher availability to critical sites across the State, and if we can assist you further we would be - I would be happy to take that question on notice for some more headline –

Mr VALENTINE - Things like the electronic records management system. People have been trying to put that in place for years and I don't know whether it's in place now or not, where that's up to, whether you're still relying on physical records of whether they have been, sort of, pulled into the electronic system or not. It is those sorts of things, and how the department has done –

DEPUTY CHAIR - Have they? The electronic records, have they been –

Mr FERGUSON - I will ask the Secretary to expand, but yes, we now have a digital medical record across the state which is not the final and best solution either, but it is progress on the paper based systems.

Mr PERVAN - Yes, the DMR as you know is a scanned medical record but it is a step towards full electronic health record, and in fact –

Mr VALENTINE - Yes, I know what you're saying.

Mr PERVAN - It is interrogatable but not editable.

Mr VALENTINE - Yes, that's right.

Mr PERVAN - But to Tasmania's credit, the Royal was the alpa site nationally and the DMR has now rolled out across several states as an interim step towards the full e-Health record. For the health system, of course, what we're trying to do is to do these two - meet the Commonwealth's initiative around the My Health Record, and integrate our effort with theirs so that we end up with a national e-Health record.

DEPUTY CHAIR - So it will talk to each other?

Mr PERVAN - They will talk to each other, yes, and in fact, Tasmania was also the first state to be able to upload the pharmacy record into people's personal health record. So as much as we're little, we do punch above our weight in some areas.

What we are trying to do, and I guess it's hard at this point to articulate it very, very clearly for you, is, we have substantial infrastructure refurbishment to undertake at the same time as we are going through and risk rating the applications of which we have - Mike, can you remind me of the number? We have over 400 applications that we manage on the DHHS network, and some of them go back many years, even before your time in the department, and so we are going through and making sure that –

Mr VALENTINE - Must be ancient history. I started in about 1991 in the health space.

Mr PERVAN - We will finish what you started.

Mr FERGUSON - When we break for morning break, I will tell you the one that causes us the most concern are the most powerful –

Mr VALENTINE - I hope it's not one I put in place!

Mr PERVAN - No, that's still in use every single day as you probably are aware. So as well as fixing up the railway tracks, if you like, we are also looking at the stock that's on the tracks, so we are going through and risk rating all the applications we have got, what are no longer supported and some of them are no longer supported by the manufacturer, and what are still key operational ones, and of course we have got newer ones like the I-Patient Manager, patient software that is used across the THS, but what we are trying to do is move to a point where, as you have been seeking for the last few years, these systems can actually talk to each other and it's actually a push across Government as well. It is not for this discussion, but the Department is also beginning its journey for a new child protection system, which is the one that you know best of all, and part of the goal of that is to end up with a system that can also communicate with Education and Police, because at the moment they are quarantined systems, and for responses to things like family violence you need to be able to integrate data in real time.

Within the health system we can do that increasingly, and certainly IT services have been good at coming up with what I euphemistically call MacGyver solutions over the years using various Microsoft products to get one package to talk to another. This time it's going to be planted, built into the infrastructure. So it's a journey we have just commenced. We have already invested with the minister's support in that redundancy issue this year, so we are going to progress through until we are up to speed with a digital standard that you would find in the bigger states.

Mr VALENTINE - And I'm sure we could talk for hours on this, but I don't wish to do that.

DEPUTY CHAIR - We are not going to do that.

Mr VALENTINE - Thank you for that information. I will certainly look forward to getting a bigger picture. The north-west, at some stage there was an external service that was being provided. It involved a digital system and the contract wasn't something that could be relet because it didn't have an end date. Do we have many contracts for digital services that don't have an end date these days?

Mr FERGUSON - I think that was a parallel drawn with the North West Private Hospital which was an evergreen contract. Do we have, Secretary, any evergreen contracts with IT providers?

Mr PERVAN - As far as I know we do not. We have been very careful about that. Our problem is that we have some contracts that have expired, but we still have the software that we have to maintain because we haven't been able to over years past upgrade replace or renew on a planned basis going forward. It is always been the crisis of the day or the one that's fallen over. So I'm not aware of any evergreen contracts in the IT area, no.

Mr FERGUSON - Mr Valentine, if I may just add to all of the foregoing, so the Government opting to set up this fund for whole of Government IT transformation projects, being the SIIRP process, is going to be adopted, and so because of your - most years will talk to me, ask me questions

about project management. You will be also pleased to hear that the process ensures that the identified projects are properly scoped and planned before committing implementation funds, and that allocated funding is released at appropriate times. So that's a gated process which will take into account the Australian Government ICT Investment Principles, together with approaches in other jurisdictions, which as you would be well aware, have at times not been adequately managed, and we have a particular risk that I don't wish to expound on here, but I would happily do so with you in private which we sought to be funded through the budget process and the $80 million more than exceeds what we asked for for the critical area of risk that we want to deal with as soon as possible.

Mr VALENTINE - Thank you.

DEPUTY CHAIR - In your One Health System new services, I know it's in the out years in forward Estimates, so there's about $16 million, nearly $17 million over two years, can you outline the service reconfiguration that will be covered in that aspect of the funding?

Mr FERGUSON - I can in broad terms, and I will ask the Secretary and Deputy Secretary to also prepare the - if they can quickly do so from last year's budget which also provided funding in the intervening years for One Health System service improvements. For detailed answers to these questions, I would invite that question during the THS output as well when I have the –

DEPUTY CHAIR - All right. I can leave it until then, that's all right.

Mr FERGUSON - I would like to say that there's a lot of further work required to plan in detail and to which specific service upgrades will be funded using those resources, but the Government policy on this is that any new services must be designed in accord with the white paper which, as you know, has a significant service upgrade pathway for a number of northern and north-western hospitals, and some of the upgrades, for example, in the south - sorry, which is a statewide service upgrade but centred in the south, such as the statewide Trauma Service has already been implemented. So we would be happy to take more detailed questions on that and I will just invite you to be aware that there are many business cases that are before governing council. They can't all be funded at once or indeed it would be unwise to attempt to embark upon them all at once, and so that's something that governing council, now being aware of their new budget profile for the following four years, when we do get to the budget output group in THS I'm sure I will ask say that there's more work to be undertaken to identify which business cases will be adopted and what timeframes.

DEPUTY CHAIR - We can leave it to the end if you prefer.

Mr FERGUSON - I can give you some broad further information. The key actions taken already include the North West Cancer Centre. You will be pleased to know that's had 6509 attendances for radiation therapy treatment and the –

DEPUTY CHAIR - Shows the need for it.

Mr FERGUSON - Indeed. No question.

DEPUTY CHAIR - Sad but true.

Mr FERGUSON - No question about that, and I told the other Estimates Committee of the House earlier this week that more than 7500 expected patient trips prevented to Launceston, and in fact there's been 8000 in the first year, so it has first more than met the expected savings of patient travel. The transfer of birthing and in-patient maternity services to the North West Private Hospital in November 2016 to improve sustainability, safety and quality has occurred, and if there's interest later in discussion about locum cover costs, particularly in the north-west I'm pleased to let you know that the ability to recruit obstetrics and gynaecology consultants to this service has seen a significant reduction in the use of locum and consultant staff.

The Mersey now provides same-day and overnight elective surgery admissions in the surgical centre model. The establishment of the Integrated Trauma Care Service in Tasmania –

Mr GAFFNEY - Sorry, on the Mersey with the elective surgery, do you have numbers there of where those patients come from?

DEPUTY CHAIR - Can we do that in the THS perhaps, Mike?

Mr GAFFNEY - All right, then.

DEPUTY CHAIR - Yes, we will drill down into these. There is a number of areas we need to drill down. We will do it in that outline if that's all right.

Mr GAFFNEY - Yes.

DEPUTY CHAIR - Yes, mark it down.

Mr FERGUSON - Yes, we will mark that down and we will see what we can provide when we get to that.

Mr GAFFNEY - All right, thank you.

Mr FERGUSON - That gives us time to ask for that advice as well.

So I'm just saying that the Trauma Care Service which I referred to earlier, led by a statewide Trauma Service Director and Trauma Nurse, so clinical advisory groups and clinical service areas have reviewed their service of each acute hospital to ensure that service does not exceed the complexity level that's assigned to the clinical services profile through the white paper and also to identify any realignment requirements to deliver a statewide service delivery model; the implementation of a single statewide electronic credentialing system with transparent credentialing processes and on-line visibility to ensure the scope of practice of our clinicians aligns with the scope of practice of our facilities; the implementation of a single statewide risk policy framework and risk register; the commissioning of a statewide patient experience survey to actively learn from our patients' and carers' experiences; and the THS is reprofiling the Mersey to increase access to sub-acute care services in the north-west.

So we have often heard much about the services that have been removed from the Mersey, and that is understandable that the community would be focussed on that, but the new focus will be on the new services such as rehabilitation, palliative care and other outpatient services that will be provided either for the first time or at a much expanded level.

When we have the THS Executive here we can expand on those future goals, but the note in point will be that the governing council will need to consider the competing priorities that have been put forward by clinical advisory groups now that they know - now that the THS governing council will be aware of what it's resourcing is.

Output group 1
Health services system management

1.1 Health services system management -

DEPUTY CHAIR - Any other overview questions? No. We will move then to Output Group 1.1 Health Services System Management, and I will just start off with one here. There were a couple of questions related to this area, one of them did. The footnote to Output Group 1 in DHHS mentions, 'Mental Health and Other Commonwealth Own Expenditures', and in answer to the break-up of grants goes some way to explaining the Commonwealth Other Purpose Expenditure, although this also, as I understand it, relates to the THS and not all the Output Groups in the DHHS.

The Commonwealth and Other Purpose Expenditure is only about $5 million, so that's the public health one. We will just get the right one, yes, $150 million in 2016-17, and $160 million in 2017-18, that's from the answer you provided to me last night, minister, but this actually comprises quite a few line items in the whole department. So this is why it's difficult to see what's being spent where. So can you give me some more information about what the mental health spending is, for instance, in this section, as opposed to the Commonwealth and Other Purpose Expenditure?

Mr FERGUSON - Ms Patterson, the Acting Chief Financial Officer.

Ms PATTERSON - So in the Direct Program Area Costs, what we have is $6.5 million of Mental Health and Alcohol and Drug Directorate costs, so they are Direct Program Area costs. We also have $16.9 million in relation to our mental health grants to organisations to provide mental health services.

DEPUTY CHAIR - Just bring the microphone a little closer. You are very softly spoken and that's hard for Hansard.

Ms PATTERSON - So do you want me to repeat that?

DEPUTY CHAIR - Just that last bit because I didn't hear it very well either. Maybe it's me.

Ms PATTERSON - In terms of the mental health expenditure that's against this output, we have $16.9 million of mental health grants, so they are grants that we provide to non-Government organisations to deliver mental health services, and we have $6.5 million of direct mental health costs in terms of the essential Directorate within the department.

DEPUTY CHAIR - Yes, I don't know whether - might have been the member for Mersey had a question on mental health services that are outsourced to NGOs. Did you want to ask -

Mr GAFFNEY - No, not here. Later.

DEPUTY CHAIR - Not yet? All right. I understand that this area covers the community-based mental health services and the THS covers the in-hospital base.

Ms PATTERSON - That's correct.

DEPUTY CHAIR - So if it's community –

Mr GAFFNEY - Yes, if that's all right.

DEPUTY CHAIR - You didn't discuss with us where it fitted, you see, and I think it probably fits here.

Mr GAFFNEY - The media release on 15 May or updated from the minister announced the, I'm not sure if it's M-I-Care or MyCare, I wasn't quite sure how that worked because when you read it in the paper you're not - so I'll say the M-I Care Program from Baptcare received the money or funding for the next four years, $7.2 million. Could the minister describe perceived advantages and success experienced thus far with MiCare and how the allocation of that money will be utilised, and how many patients perhaps were supported in 2016-17 through that program? I was interested to know more about it and was going to raise it but this is probably a better time to do it, so thank you.

Mr FERGUSON - I'm very pleased to speak with you and the committee about this. It is a specific commitment of Government which builds on an existing model which as, I believe, proven itself on short-term federal funds, somewhat a pilot stage of a project, if I can put it in that description, and with that coming to a close the Government, Tasmanian Government, made the decision that this was too good to not continue.

So the Government is providing $11.4 million over the next four years in this budget to fund, I'm advised that it's pronounced My Care, but yes, M-I Care Plus, so MiCare, MiCare Plus and I-Connect, so these are three initiatives. $1.5 million per year for MiCare; $360 000 per annum for MiCare Plus; and $1 million per year for I-Connect.

Mr GAFFNEY - What's the difference between MiCare and MiCare Plus?

Mr FERGUSON - Taken as a total it is approximately 100 packages. MiCare and MiCare Plus have been provided through Baptcare which is the, MiCare Plus is a more intensive program, more complex and challenging clients to receive a more intense support package. So the programs do outstanding work in our community to assist those with severe and persistent mental health issues with individualised packages of care providing intensive tailored programs, and what would we be wanting to achieve out of all this is to help people continue their journey to recovery away from hospital. That is the whole point. The clients who are involved with the program are a strong testament that it works.

I met one gentleman on the day of this announcement who was very suicidal and really struggling with life. He is virtually a graduate of this program and has returned to his best life. They experience far lower contact as a result of being part of the program with Mental Health Services after being involved, including significantly reduced likelihood of requiring admission to hospital. The patients are also less likely to present at EDs around the State, meaning less pressure on our hospitals and better care for people closer to home. So that's MiCare.

Mr GAFFNEY - On that MiCare one, is it possible to get a breakdown of where those services are throughout the state?

Mr FERGUSON - Yes, it is.

Mr GAFFNEY - And the numbers that - it would be good for us to see where the funds are being used.

DEPUTY CHAIR - And the programs that this is linked to.

Mr FERGUSON - So I can attempt to provide you that information, but let's be very clear, these are statewide initiatives so it may depend on where, at any one point in time, the next needful client actually comes from and lives. I will take that on notice, Mr Gaffney, and provide it either today or as soon as it's available.

Mr GAFFNEY - Thank you.

Mr FERGUSON - So I-Connect works on a partnership model for children, so it works on a partnership model with parents and other family members, and also our state-provided service CAMS, Child and Adolescent Mental Health Services.

The focus is on providing high intensity support to young people as soon as possible to improve their health and reduce their reliance and need for acute mental health services as they transition into adulthood. All of the above funding is very firmly in line with our Rethink Mental Health Plan. Our plan recognises that hospitals should be a treatment space of last resort for people wherever that is possible.

Now, we must, and will, and always want to provide hospital based care for those who require it, but the very clear intention of this Government, and I believe it's fair to say the previous Government, was to try to shift resources more into the community where that can be safety done to assist people with where they are at that point in time, and allowing them to step up before needing hospital, and also after a hospital admission to be able to step down.

Mr GAFFNEY - I think I cut you off there and I apologise for that. You were talking about MiCare and then you were just about to go into MiPlus [sic], and you didn't, you then when you came back to speak you went back to the I-Connect Program. So just if you could say the Mi Plus one?

Mr FERGUSON - This is what I have to hand. So MiCare Plus is for 'super complex packages'. That might be a bit rhetorical, but to help us understand what that means, it's an expansion of the packages of care program provided through the more generic MiCare. MiCare Plus: 'High cost, high intensity packages and are supporting clients that have a history of lengthy in-patient admissions and associated complex co-morbidities'. I am giving one example. For example, people co-occurring mental illness and Huntington's disease would be one example. So super complex packages have enabled people to be discharged from hospital into an appropriate regime of support to receive additional supports into the community. So that's what that funding of $360 000 per year is targeted at.

Mr GAFFNEY - And it's a casework arrangement? Is that how it operates with that care?

Mr FERGUSON - It is a package of care, and I will just check the exact language around the nature of the vocational group that will be providing that. So you would also like to know that referral to get into this service occurs via both MiCare and MiCare Plus; occurs via public mental

health services; and a partnership model operates between MiCare and public mental health services to support clients and ensure clinical and psycho-social supports.

So what you have asked me to do, and which I will now undertake to give, is a break-down of where these around 100 packages will be physically provided, and I'm sure that it will be the case that it needs to be a flexible, somewhat flexible to be able to meet demand as it occurs and where it occurs. So that's a partnership model with Bapt care for MiCare and MiCare Plus, and Life Without Barriers for the I-Connect initiative.

DEPUTY CHAIR - Is there any plan to look at supported accommodation for people with Huntington's at all?

Mr FERGUSON - I can broadly say there's been some work, very good work done on this by my colleague, Mrs Petrusma, and I will bring that to the table during the day if I can, yes.

DEPUTY CHAIR - Good-o. Just going back then –

Mr FERGUSON - And that is in the north-west area of the state, but I it's not –

DEPUTY CHAIR - We have a number of people up there that suffer from Huntington's.

Mr FERGUSON - We do, and we have a shared commitment to this. That supported accommodation work is something that my colleague can take much more credit for than me.

DEPUTY CHAIR - Thank you. Just going back to the answer to the question I received last night regarding the break-down of this output group, the Australian Government funded programs and services, are you able to just break those down further? Do you want someone to do that for you or –

Mr FERGUSON - I do, but can you just clarify what sort of break-down you would be looking for?

DEPUTY CHAIR - What programs - do we have a list of these programs?

Ms PATTERSON - So they would be in our EPAs and COATs.

DEPUTY CHAIR - That refers to all of those?

Ms PATTERSON - Yes, so they would be ones that go through this output, so some of them might be, the Aged Care Assessment Program, the Rural Health Outreach Fund, Medical Outreach Indigenous Chronic Disease Programs are there through here, our HACC NPAs and our Mental Health NPAs are through here.

DEPUTY CHAIR - We have lost something then because it drops down significantly from the estimated outcome to the budget for this year. What has been - is there an EPA come to the end or something?

Mr FERGUSON - So Chair, can I just invite Ms Patterson, and/or the Secretary, to just indicate the extent to which the Tasmanian Health Assistance Package winding up is relevant here?

Because that was delivered through an NPA. Anyway, there's time-limited funds that have obviously concluded.

DEPUTY CHAIR - They have expired?

Ms PATTERSON - Yes, there are time-limited funds. I am just trying to see which ones actually fit within this output because with the funds you're referring to, minister, actually will be output 1.2.

DEPUTY CHAIR - That is why I said it's hard to know where these things actually impact. I will let you seek to find that if that's all right, minister. There is also a line there for –

Mr FERGUSON - Thank you, if we can get it down exactly, then I will give you the answer that you require. What is the exact question that you would like us to take on notice?

DEPUTY CHAIR - The estimated outcome for the Australian Government-funded programs and services goes from $11 million, or $11.02 million basically in the estimated outcome for this year, to $5.5 million next year. So obviously we have lost –

Mr FERGUSON - Are you looking for a break-down of which those expiring agreements are?

DEPUTY CHAIR - Yes. Obviously one has expired, I would say. There are also overhead costs –

Mr FERGUSON - How does your process here work? Do we take that on notice in writing or do I just undertake to provide it?

DEPUTY CHAIR - If you can provide it during the day that would be fantastic. But if we don't get these ones - we will put them on our list. If we get them during the day we will take them off and those that are outstanding we will send to you at the end of the day.

Mr FERGUSON - Just so you understand, we have excellent officials behind me who are recording the things that I agree to take on notice, and anything that we can provide through the day we will, and any others –

DEPUTY CHAIR - Yes, which we would much prefer.

Mr FERGUSON - And any others will work through the committee system.

DEPUTY CHAIR - All right. So further, you have overhead costs, $21 million estimated outcome this year, $31.5 million next year. What do those overhead costs relate to? The footnote does say it's the Corporate Services. Is that - it seems like quite a lot of money going to Corporate Services. I am just wondering what it actually covers.

Ms PATTERSON - So they do probably only relate to costs within the Corporate Policy and Regulatory Services Division, and they are applied across the agency on an overhead basis, and –

DEPUTY CHAIR - Right, so the THS as well or just - the DHHS. Right.

Ms PATTERSON - This is just the DHHS component, yes.

Mr FERGUSON - Deputy Chair, I'm getting advice that the line of questioning that you're pursuing, while legitimate, will, I think, relate to information that will not be readily to hand because of the way that the accounting is presented. It doesn't mean that we can necessary go down to always that level of detail, but we will attempt always to do that.

DEPUTY CHAIR - That's fine. The other question, the last of mine, is provisions. Which provisions relate to significant and unanticipated costs across the department, and again there's $20.5 million in this year's spend and $22.7 million next year. It seems a lot for unanticipated costs in DHHS. I am sure this is across the whole department, not just the Health part of it, Human Services and everything, is it?

Mr PERVAN - Yes, that's correct.

DEPUTY CHAIR - So it's a fair buffer, I'm saying, there, I think you would agree in the budget?

Mr PERVAN - It is a fair buffer. We are dealing for $1.6 billion budget so it's a significant budget in that sense.

DEPUTY CHAIR - $1.6 billion includes the THS though, doesn't it?

Mr PERVAN - That is the payments, yes, indeed. The minister made reference to the work we did with improving the robustness of our ICT system, for example, this year which we are very pleased to be able to do, and this is where, for example, that funding came from for the ITC system which cost us over $5 million this year.

DEPUTY CHAIR - All right. It's helpful to know that sort of thing; these things are important the ICT funding.

Mr PERVAN - Indeed, and as you can imagine, there are always pressures within both the Health and Community Services side of our business and we like to manage our department on a sustainable basis and not always go cap in hand to Treasury with these things, so we ensure that we have some flexibility where possible to manage those pressures in our system.

DEPUTY CHAIR - So some of the provisions here could be spent in THS or is - it's not in the THS? It is just the management of the DHHS?

Mr PERVAN - It is allocated here because we don't know ultimately where some of these provisions may ultimately need to be spent. There have been years gone by where the Department has assisted the THOs and THSs through some of their financial pressures, and we would draw funds or transfer funds from a provision like this.

DEPUTY CHAIR - The reason I'm asking this is when we, some time down the track we will get a RAF or a section 19 report that shows some shifting of money or the request for additional funding. This is obviously in addition to this because the provisions would have been expended before you go down that path?

Mr PERVAN - That's right. You will also see transfers between outputs. We are required to report those under the section 19 requirements.

DEPUTY CHAIR - I understand those, yes. I know it's not more money spent. It is just transfers within - yes.

Mr PERVAN - That's right, so if there is any significant shift of funds from one output to another, it's always reported and tabled in the parliament.

DEPUTY CHAIR - Did you have other questions here, Rob, this line item?

Mr VALENTINE - Yes, just with respect to the Health, can you give us an overview of what's happening in that space, because obviously e-Health is a great way to keep people in their area as opposed to having them travel huge distances to see a specialist who might not be available on that day when they finally get there, so, and all of the disruption that that causes.

Mr FERGUSON - e-Health is very to all of us in Health, and utilising developments in ICT to deliver health information and services more effectively is the goal. We want data to be more accessible to clinicians, but also supporting developments in research and innovation. Improving e-Health and ICT support, access to patient information and coordination of service are all keys outcomes intended through the One State, One Health System Better Outcomes White Paper, and we touched on this earlier, but development of the new ICT and e-Health strategy for Tasmania is being progressed by the Department, and particularly with the new leadership of our, our freshly recruited Chief Information Officer.

Three initiatives, completion of an ICT infrastructure assessment and the progression of a work program in response to those identified issues which we touched on earlier; development of an ICT applications assessment to determine the risk profile associated with our existing portfolio of information systems, again which we touched on earlier; and also now working close with THS to identify current and future ICT needs to support the business requirements of a single health service.

You would be well aware that the Australian Digital Health Agency commenced operations on 1 July 2016. My Secretary is a member of the Board. The ADHA is finalised a new national digital health strategy and implementing priority actions. The Australian Government Department of Health is responsible for national and digital health policy. However, you may be aware that recently, I think it was in March, that Health ministers met through the COAG Health Council and agreed to move more rapidly to the opt-out model as opposed to the commencement which was an opt-in model. So Tasmania continues to collaborate around that, and we are involved in the delivery of the broader work program at the local level.

Implementation of the My Health Record, the national digital health record system, is continuing. Public hospitals can now upload discharge summaries as well as prescribed and dispensed medications to the record as the Secretary earlier mentioned. The diagnostics to the My Health Record Project are currently under way. We will introduce the capability to upload pathology and diagnostic imaging reports, and allow clinicians to view the My Health Record through their digital medical record tool. The project is expected to be completed in late 2017.

At this point I might conclude and listen to any other questions, but make one final observation, that while the Government hasn't formally responded to the House of Assembly Standing Committee on Community Development one of the recommendations of its Inquiry into end-of-life care was for greater disability of any advanced care planning or advanced care directives, something I'm very attracted to, and for that to be visible and available on the My Health Record, and/or the

patient's hospital-based digital record, I think is very attractive and something that I would like to explore further.

DEPUTY CHAIR - But doesn't that occur already, minister?

Mr FERGUSON - The Standing Committee Inquiry Report recommended that it be made in visible in a way that's very apparent.

DEPUTY CHAIR - So an approach to asking patients for their advanced directive?

Mr FERGUSON - I am not sure that it was quite at that level, but more that if there is one, for it to be very apparent on an examination of the health record.

DEPUTY CHAIR - It's an area I have great interest in too, and many people are aware that they can get an enduring guardian in place and you can give that information to the hospital as your right. An advanced directive can be more prescriptive than that obviously. So in your consideration of this, will you consider some sort of regulatory change or is it more a policy thing that can be - a policy level it can be achieved at?

Mr FERGUSON - The Standing Committee made up the 26 recommendations, one of which was about ensuring that the existence of an advanced care directive was very apparent to any clinician using the digital record, and that's what I was referring to, but it did make other recommendations around regulation which the Government hasn't given a - is considering but hasn't yet given a response to.

Mr VALENTINE - That's fine.

DEPUTY CHAIR - If this is a different area, then you can just point me to it. The Health Transport and Coordination infrastructure. Do you want to deal with that here or is that better in THS?

Mr FERGUSON - That is a project being led by the department.

DEPUTY CHAIR - Yes, I would like a bit more of an update on where that - because I think this is a crucial aspect of your One Health System which I applaud and strongly advocated for in this, particularly the Transport and Accommodation Support coming from the far outer reaches of the State.

Mr FERGUSON - So supporting access to better health services is a key outcome of the white paper and our health improvement performance. The Government provides $24 million to coincide with the release of the white paper over the four years to improve patient transport and also to support implementation of that white paper. The commitment included $5.4 million for 12 paramedics in the Latrobe-Devonport area. These positions have been filled and they are now operational. Funding for extended care paramedic and first intervention vehicle in Launceston, and this project has been completed and since then also that's been stood up in the south state of Hobart. There is funding to enhance Tasmania's retrieval and referral services. This project has been completed. There is funding to enhance non-emergency patient transport. This project has been completed and the Secretary, if you wish, could expand on that and how the Government has gone through a new process to establish a panel of private providers just –

DEPUTY CHAIR - That would be good if, when you finish, if you could do that.

Mr FERGUSON - To supplement Ambulance Tasmania provision. We could go into in the best detail during the output for Ambulance, however the Secretary is here.

DEPUTY CHAIR - I am happy to do it in Ambulance if that's more appropriate, but it is separate to Ambulance, though, isn't it?

Mr FERGUSON - It involves Ambulance Tas by consequence.

DEPUTY CHAIR - I will leave it until then.

Mr FERGUSON - Of the fact that we retain the public provider and also have the private panel. The Patient and Family Hospital Transport Service has been introduced between Latrobe through to Burnie. That has been introduced and the option for the Launceston to Latrobe Service are currently being finalised, Hospital Link as you would be aware, and of course, funding for patient transport and reducing travel demand; a review of the eligibility criteria for Patient Transport Assistance Scheme, PTAS, and the review of demand - sorry, the TeleHealth Expansion Project which needs to be further developed, however is well under way and some TeleHealth Clinics have already now been established.

DEPUTY CHAIR - Whereabouts are the ones that have been established?

Mr FERGUSON - I'm going to call on the Secretary now, but I can name that, for example, there has been a particular focus on those TeleHealth clinics being provided to the north-west community.

DEPUTY CHAIR - Before Mr Pervan starts, the other thing is accommodation for patients and their families who need to travel for access to health care, if that's also been considered and progressed at all?

Mr FERGUSON - That would be through PTAS. Is there a more detailed question that I can answer?

DEPUTY CHAIR - Yes, you talked about the increased, or reviewing the eligibility for PTAS, so I'm just wondering what that encompasses.

Mr FERGUSON - While the Secretary is preparing his thinking on that, on your question on TeleHealth, so the aim of the TeleHealth Expansion Project, which I think is the future by the way, it shouldn't be seen as an attempt to replace or cut out local permanent staff specialists where we can recruit to that service in a safe and sustainable way.

DEPUTY CHAIR - You might have appreciated my comments on ABC radio about that yesterday then.

Mr FERGUSON - I was nodding, and I agreed.

DEPUTY CHAIR - Were you? Good.

Mr FERGUSON - Yes.

DEPUTY CHAIR - Yes, we do agree on a lot of things.

Mr FERGUSON - We do. I was nodding in agreement. I have an example from your electorate on 7 February this year. The first TeleHealth appointment between the Royal Hobart Hospital Wellington Clinic and the King Island Health and Hospital Centre was successfully delivered.

DEPUTY CHAIR - Excellent.

Mr FERGUSON - You can imagine what would have happened without that. The patient would have been required to travel to Hobart for an in-person consult, or perhaps the north-west regional for a TeleHealth appointment. So that didn't just save an air fare and –

DEPUTY CHAIR - A very expensive air fare.

Mr FERGUSON - Yes, and travel cost on land, but it also saved that patient significant time, and we need to value the patient's time. I think that that's an important element, but it's also been kinder on the budget.

DEPUTY CHAIR - So it's cost effective.

Mr FERGUSON - So it's just better for all around. So the key aim of the TeleHealth Expansion Project is to deliver sustainable and scalable TeleHealth Services into THS by supporting patient-centred care at distance, reducing travel time for patients, and delivering improved access to services.

In September, General Endocrine and Endocrine Neoplasia Clinics commenced delivering TeleHealth Clinics services. Since this time, 70 appointments have been offered.

DEPUTY CHAIR - Where was that? Where were they delivered to?

Mr FERGUSON - The North West Regional Hospital. They were delivered from - of course, it's two-way communication, but it was delivered from the Wellington Clinics here in Hobart, and the patient accompanied by a Registrar at the North West Regional Hospital. The High Risk Foot Clinic for diabetic patients with complex foot concerns also commenced delivery in September last year, and since this time 19 appointments have been offered. The introduction of these three TeleHealth services to Endocrine patients.

DEPUTY CHAIR - You would have to be agile for that, wouldn't you?

Mr FERGUSON - Agile in what way?

DEPUTY CHAIR - Hold your foot up to the camera!

Mr FERGUSON - I think the cameras can move.

DEPUTY CHAIR - The visual is interesting!

Mr FERGUSON - The first joke at Estimates for the week.

DEPUTY CHAIR - You have to have some, seriously.

Mr VALENTINE - It has got to be light-hearted at some point.

DEPUTY CHAIR - That's right.

Mr FERGUSON - And it wasn't good.

DEPUTY CHAIR - Better than Mr Pervan's before we started.

Mr PERVAN - True.

Mr FERGUSON - To state the obvious, this means patients no longer need to travel from north-west Hobart to receive specialised care.

I mentioned the first TeleHealth appointment with King Island on 7 February. So the TeleHealth expansion project is continuing to work on opportunities for expanding the use of TeleHealth services, on improving the availability and quality of technical services available in clinical areas, and also important established sustainable governments for the ongoing use of that in our State so that it can be no corners cut, no compromise, but using what the technology has to offer as an instrument of bringing the clinician and the patient together in a way that is in clinical terms, and for the patient's purposes, as good as a face-to-face, but with the convenience of being able to receive that care in the community.

It may not mean all of their engagements with that consultant are using VC, but if even some of them can be, then that's a significant advantage to the patient and it supports our one health system approach.

DEPUTY CHAIR - When I was travelling overseas a couple of years ago, I visited an innovation centre in Germany where they were actually delivering physiotherapy to patients' homes with an interactive - I forget what they call it - kids stand at it and do things with a computer. I've forgotten the name.

Mr VALENTINE - Like a Wii?

DEPUTY CHAIR - Wii, that's right. Like a Wii, yes, and it was really interesting because the physiotherapist was in another location, but they could move their arms or their legs, and the person would have to move with them. If they didn't do it right it would clearly show on the screen, and it was very simple and very effective and it saved patients having to travel to receive physio.

Mr FERGUSON - I am pleased to tell you that I have seen that precise technology in the repatriation hospital here in Hobart.

DEPUTY CHAIR - They have actually adopted something?

Mr FERGUSON - It was not with a Wii but with a Microsoft platform using the Konnect mechanism using that camera, and –

DEPUTY CHAIR - Yes, same sort of system. It was an Apple system I was looking at, yes.

Mr FERGUSON - I have seen a person balancing on a platform and being able to measure their balance and their ability to lean on each direction so they could build strength on one side which had been affected by some neurological condition, perhaps a stroke, and that was a young person too, so that was very pleasing to see.

DEPUTY CHAIR - There is obviously a lot more potential for this sort of stuff.

Mr FERGUSON - I think so, and the technology is now inviting it. Now, of course video conferencing technology is not new, but it's been a problem for it to be user-friendly for a long time. The technology has evolved to a point where the resolution is improved, but the real time, what would you call that - symmetry of the connection, so that you're not waiting for the other person.

DEPUTY CHAIR - Has to be real time.

Mr FERGUSON - It is real time.

Mr VALENTINE - It is not time lagged.

Mr FERGUSON - It is not lagged, thank you, you are right, and also you are not - the newer technology is not requiring the need to book a line if you are making a call like a phone. You ring when you want to ring rather than waiting for a third party to set that up. So that is the future. We are still making baby steps in this area, but we have made a genuine attempt to commence the project and it is working, and it is something that you will watch for any length. We just want to continue progressing this because we shouldn't - we should attempt to see it as a vehicle to supplant patients travelling to large population centres for their consults.

Mr VALENTINE - For all sorts of reasons.

DEPUTY CHAIR - And there are some, as I said on the radio, you have got to - with major surgery you have to go to the centre, but other care can be provided away from that.

Mr FERGUSON -Yes.

DEPUTY CHAIR - So on-off care.

Mr VALENTINE - Just a supplementary to that in the sense that whether or not there are any trials happening in homes, so I was aware that there are machines in people's homes that actually help specialists monitor an individual who might have a chronic condition of some sort long-term, and -

DEPUTY CHAIR - Monitors their vital signs.

Mr VALENTINE - Yes, and they can interact with the specialist as well by telephone that the device readings are going across as well at the same time, so I was just wondering whether any of that is happening in Tasmania as a trial or anything?

Mr PERVAN - Actually one of the ones that's perhaps the most exciting is a trial that was conducted initially by the CSIRO and one of their trial sites was Launceston and that was remote monitoring and people with diabetes, and being the CSIRO, they did it big and they did it right, so

they reviewed every device that was internationally available and settled on one that was the most effective, the most user-friendly and so, and they picked different populations, with one group that was predominantly aged, one with younger diabetics and so on so they could get some idea and comparisons of the useability of it, and the results of the trial and the training packages that were put together with patients showed a fantastic decrease in people who were having to either go to their GP, or in the worst case scenario, turn up at a hospital Emergency Department because their sugars were out of control or because they started suffering the adverse effects of the diabetes.

So Launceston was part of that national trial, the results were published and I don't have the link on me, but if you would like to have a look at the report on-line it's really quite exciting for what it's suggesting in terms of the future of diabetic care in particular.

Mr VALENTINE - Yes, I'm thinking of people on the islands, like King Island and Flinders Island, where they really are isolated and it's very expensive for them to travel off the island. There must be opportunities. Thank you.

DEPUTY CHAIR - Yes, I'm sure there are opportunities coming, but PTAS?

Mr PERVAN - Yes, I was wondering - so I have got your answer on this as well.

DEPUTY CHAIR - Good, excellent.

Mr PERVAN - So the component of the patient transport initially around Patient Transport Assistance Scheme, which sits side-by-side with the expansion of TeleHealth, so the Department conducted the review of the scheme in two stages. The PTAS ministerial policy was amended in December 2015 to include eligibility for patients travelling to the Mersey for elective surgery even where the procedure was offered where they live closer to home, outside of that region, so that was a specifically deviation from the policy to support the Mersey's role.

Obviously, to state the obvious, there still is a need for the person to be willing to do that, but nonetheless the policy itself was amended to support that.

DEPUTY CHAIR - It makes sense.

Mr PERVAN - For example, a patient in Hobart, if they were willing to take up an opportunity to have their day surgery at the Mersey, PTAS wouldn't previously have supported that and it does now.

Secondly, and in-depth review of the Governance Administrative Structure and Eligibility Criteria of PTAS was completed by the Department to ensure that it was capable of meeting the requirements of health reform. The review made a number of recommendations to improve the functioning of the scheme. Those recommendations were all accepted by the Secretary of the Department and the CEO of the THS, and it's been referred to the PTAS Advisory Committee for implementation.

One of those recommendations, just to pick one, was establishing the feasibility of fuel cards to allow eligible patients to be issued their travel subsidy in advance of the need to travel, and that's self-evidently useful for some people who would find it difficult to meet the immediate out-of-pocket and to find reimbursement later.

DEPUTY CHAIR - This has been a commonly expressed concern in my electorate.

Mr FERGUSON - Helping them with their cash flow and cash management.

DEPUTY CHAIR - That has actually started, that -

Mr FERGUSON - No, I was just about to say that it's expected that the recommendations will be implemented in the second half of this year, and some preparatory work has occurred on some of the recommendations. Some preparatory work has occurred, but implementation I am advised is second half of this year, and that will need to be carefully implemented because what I wouldn't want to see, for example, with the use of fuel cards, I wouldn't want to see people provided with a fuel card that in fact wasn't used to support their travel and then they weren't then able to get to that appointment, so I think that there's implementation by good, well-meaning people there to make sure that it actually works for the individual.

DEPUTY CHAIR - You would have a limit on it or something like that? Anyway that's something to be worked on, I'm sure, yes.

Mr FERGUSON - So the reimbursement model makes sense, you can understand, for some of those issues, but then it is difficult for people to make - for some people it is difficult for them to make that upfront cost of travel to be reimbursed their out-of-pockets for the intervening period, so that's intended to make it easier for them to achieve their travel.

DEPUTY CHAIR - Thank you.

Mr FERGUSON - So I want to see that happen, and obviously I think we all would like to see that occur in a way that actually supports the patient to get to the destination, effectively.

DEPUTY CHAIR - So it is also supporting patients to go to the mainland for surgery if they need to?

Mr FERGUSON - It does.

Mr VALENTINE - It is a question of nurse recruitment, whether that happens at DHHS level or whether it happens at THS.

DEPUTY CHAIR - Nurse recruitment?

Mr VALENTINE - Is that something for THS or is it something for the Department?

DEPUTY CHAIR - Yes, THS.

Mr FERGUSON - The Department does employ some nurses and also leads the work of workforce development.

Mr VALENTINE - That is more where my question would go to, so if I could ask the question -

Mr PERVAN - In terms of recruitment, yes, the THS recruits the nurses, but the Chief Nursing Officer, Francine Douce, will - often there is, especially if there is an overseas recruitment initiative under way, she will travel with the senior nursing staff from the THS to support the recruitment.

Mr VALENTINE - I guess my question, it is a broader question about - with all of these new beds coming on line, obviously they do not just sit there and work without any staff. You need nurses to be able to operate them as well as other resources. What is the situation? Our nurses are being trained through the University of Tasmania. Is it the number of nurses going through that system that basically ends up being the point of stricture as to how many you can actually employ, or are you going overseas and trying to get the people to come here to resource the opening of these new beds?

Mr FERGUSON - The Secretary and I will both answer this, and the CEO later today and our Chief Operating Officer could also add to this. So first of all, the Government has today approximately 160 more nurses than we came into office. There have been opportunities with the progression of time and the opening of some new services in different places, we have been reasonably constantly looking for the workforce to support that, and my only anecdotal advice is that in some specialty areas - no, it's not anecdotal, it's real - in some specialty areas of nursing it is very difficult to obtain the labour market supply for those services. For example, ICU nurses. It is a very clear and understood shortage. So we are recruiting to those positions, for example, to support the extra ICU beds at Hobart Hospital, the extra two that the Government is funding.

So while the beds are open we do not believe we have the best possible number of staff which is why we are recruiting to those positions as well, and as the Secretary said, in the Department we have a Chief Nurse and Midwifery Officer, Francine Douce, and she leads the work, if you like on behalf of the Health System, about supporting and engaging with our tertiary education providers, principally UTAS, for the skills that we need, and - what is the name of the university in Queensland that's training midwives? All right, we will come back to that, but we had a decision by UTAS to no longer continue offering training qualifications for midwives, so our Chief Nurse and Midwifery Officer -

Mr VALENTINE - So not a dying breed?

Mr FERGUSON - Not a dying breed. We were disappointed with the outcome that we cannot locally train. So our Chief Nurse and Midwifery Officer secured the services of the Queensland education provider for that training to continue so that we do have a continuous - so that our local nursing workforce have the ability to upskill in to that area because we always need midwives.

So just might finish my part of the answer by saying that two weeks ago on the Saturday after our budget, noting that the budget does not officially commence until 1 July, that the significant workload and effort required as a team to recruit the necessary staff to open those beds had commenced, and we did advertisements calling for expression of interest so we could begin to gather expressions of interest from Tasmanian nurses midwives, allied health professionals, medical and also paramedics and other support staff, so that we could actually have one foot in front so that we can support those recruitments to happen in a timely fashion. It is a big task, because opening and permanently funding these beds requires hundreds of additional staff.

Mr VALENTINE - And it's not a cheap exercise, is it? It is not simply, 'Let's use that room'.

Mr FERGUSON - That is right.

Mr VALENTINE - And so your specialist -

Mr FERGUSON - If you took the view that Tasmanians should be strongly encouraged to consider these job opportunities I would agree with you, but where we are not able to fill our vacancies with Tasmanian qualified personnel naturally, we would be looking interstate as well, and further if required because what we must do is stand up these extra beds so that we can improve the patient flow issues that all of us at this table acknowledge are real and we want to meet the needs of the community and not have them waiting for unacceptable periods of time in our EDs.

Mr VALENTINE - Or using nurses that are fully trained in a certain area.

Mr FERGUSON - Yes.

Mr VALENTINE - To fill the gap.

DEPUTY CHAIR - New grads can't go straight into ICU.

Mr PERVAN - In addition to the minister's comments, we recruit around 115 graduates every year and start them through their training. This year, due to some very good work in the THS by the Executive Director of Nursing, Susan Gannon, they actually recruited 140. So that begins the stock in that component of the workforce to start building through.

Mr VALENTINE - Do they go throughout the state? Where are they?

Mr PERVAN - I would have to get those figures down for you, but yes, they are -

Mr VALENTINE - We can ask that in THS.

Mr PERVAN - That would be great.

Yes, that gives us the commencement of the kind of registered nurse workforce, but from there, we have rolling recruitment for specialist nurses or nurses in specialty area, whether that be surgery, or as the minister alluded, there's a particular national shortage around ICU nurses. The Royal has historically trained their own ICU nurses, but you can't do a lot of that at one time for obvious reasons, particular when the ICU is really busy. So we continue to recruit for senior and specialist nurses and midwives. That will continue. We certainly did have the nurses to open the new beds that the Government have been good enough to fund in response to increasing demands on the Health Service, but notwithstanding that, we will continue to have nurses retiring and moving interstate, so it's a continual process, and we do have an annual recruitment for graduate nurses, but with every other sort of nurse. It is what we call rolling recruitment which is recruit constantly to meet the demands.

Mr VALENTINE - So your staff member that concentrates on the big picture, do they also look at demand in the private sector and in aged care services and the like?

Mr PERVAN - There is liaison with the private, not-for-profit and aged care sectors, but they do their own recruitments, particularly the private chains. Little Company of Mary will recruit internationally, centrally and as well as locally, so they have their own approach, but they certainly collaborate with us.

Mr VALENTINE - Because I am interested, like, if you are working with UTAS, you are not just talking about the needs of the state hospitals. You are talking - they are looking at the big picture as well, and so how much collaboration is going on there I guess is the question.

Mr PERVAN - Yes. There is probably more collaboration going on now than there ever has been, and that is largely because of conversations that have started between the THS, the private sector and with the Department. Some of it is even as a result of the nursing panel, sorry, the surgical panel contract because professional conversations have happened that haven't happened before.

The only thing I think I could add of use is the university that we have established a relationship with around midwifery training is the University Southern Queensland.

Mr VALENTINE - Thank you, minister.

DEPUTY CHAIR - Any other questions on this line item? No? We will have a break, minister, and allow your THS representatives to appear. So there is a cup of tea out in the antechamber there, and we will resume at 11. That should be time to get them here, do you think? Yes.

The Committee suspended from 10.44 a.m. to 11.02 a.m.

Output group 2
Tasmanian Health Service

2.1 Tasmanian Health Service -

DEPUTY CHAIR - Minister, if you could introduce your team at the table.

Mr FERGUSON - So I introduce to the table Dr David Alcorn, Chief-Executive Officer of the Tasmanian Health Service, Mrs Nicala Dymond, Chief Operating Officer, Mr Craig Watson, Chief Financial Officer.

DEPUTY CHAIR – Did you want to make any specific overarching comments about the THS itself?

Mr FERGUSON - I am happy to go straight to your questions.

DEPUTY CHAIR – I did not there is comment about the number of extra staff in this area you are putting on. Can you just clarify how many extra health professionals you are actually engaging?

Mr FERGUSON - Yes. And so I will be drawing on the advice of our Chief Executive Officer and Chief Operating Officer shortly but the estimate that I have received in the preparation of the budget was 350 additional staff approximately.

DEPUTY CHAIR – That is across all areas?

Mr FERGUSON - And my other advice is that the extra paramedics is additional to that number.

DEPUTY CHAIR – How many are they?

Mr FERGUSON - Thirty-five, approximately 35.

DEPUTY CHAIR – There have been different figures put out. There is a tweet from your fearless leader, it had a different number, it was 345 when you add it up. So I was a bit unsure. It is 106 more hospital beds, 35 more paramedics, 215 plus nurses. Twenty plus doctors. Forty plus allied health. Seventy-five plus support staff. So you are not sure exactly how many at this stage? Is it still a work in progress?

Mr FERGUSON - Recruitment is certainly a work in progress, and actually our Chief Financial Officer will be better placed to support this answer, but the numbers have been described as approximate. They are large numbers obviously, and recruiting specifically to allow the opening of the additional services may, in some cases, depend on individuals' willingness to be full time or part time for example.

DEPUTY CHAIR – So these are people we are talking about, as opposed to FTEs?

Mr FERGUSON - Still working through the models of care and recruitment but my advice is that that is a head count.

DEPUTY CHAIR – So not FTEs. There might be less FTEs?

Mr FERGUSON - It will depend, I suppose, on a person's willingness to be – to take up an FTE. So I am even getting other advice that it potentially may include some higher numbers than have been published, for example in the south, depending on the specific model of care that is selected, for example, at the opening of the Repatriation Centre site. So those numbers are indicative. I would invite the Chief Financial Officer to expand on that.

Mr WATSON - When government makes a decision to invest funds like this, I am sure the minister would like us to give a very specific precise number of the staffing that results, but until, as the minister has indicated, the work is done around the precise model of care that it is implemented, the rostering structures, potentially the profile of the workforce between the different types of staff that are put in, more senior more junior, we have to be a little bit approximate in the numbers that we use, so we provided estimates as to what we believe the staffing profile will look like.

But really, it will only be, even after a period of time of implementation, we will know a precise number because for instance, as I know committee members are aware the nursing hours per patient day has an element of acuity to it that until you actually understand the profile of patients going through, that potentially has an impact on the precise level of staffing that are employed.

So the key element, of course, is the beds announcement and that is a fixed number, and then the staffing really responds to delivering those beds.

DEPUTY CHAIR – So in terms of the number of nurses extra that you are expecting, I know it is a work in progress, I accept that, but what areas are they specifically being recruited to? Is it just the new beds or are there other areas that you are actually enhancing as well?

Mr FERGUSON - So the initiative around the 106 beds has recruitment needs across all disciplines, of course, as I am sure you would be well aware. The recruitment advertising that I referred to before the break, included a call for expressions of interest from paramedics. So even though THS has not employ those personnel, nonetheless we use the same call to expressions of interest, advertisement for the same end, that is to attract interest and those necessary expressions of interest forwarded to the appropriate agency, in this case Ambulance Tas through the department.

DEPUTY CHAIR – You talked about the challenges of getting ICU nurses for example. So do you have a breakdown of the actual recruitment? You have obviously done workforce planning otherwise you would not be doing what you are doing in any respects. Do you have an expectation of how many nurses you will be employing and in what areas?

Mr FERGUSON - I have previously and -

DEPUTY CHAIR – In terms of specialities.

Mr FERGUSON - Yes. I do not have the numbers immediately in front of me, but we have given an indication publically of what it would likely look like in each region, for example, with numbers of nurses using the illustration you have chosen. I do not have that other detail, but that is something that obviously I would to THS to adequately design as part of the recruitment process so that we actually match the workforce with the service expansion that we are seeking to delivery.

DEPUTY CHAIR – We touched on this earlier and you said it was better to talk about here, the one health system initial investment. Would you like to speak to that now?

Mr FERGUSON - I will invite the Chief Operating Office and the CEO to expand. So further to what I did indicate earlier governing council receive and have received business cases for a large range of service changes essentially bids if I can use that word loosely, bids, brought forward by the clinical advisory group process, and they are now with governing council.

It, of course, has the responsibility to judiciously select those service improvements to accord with the white paper, noting that inevitably, as with any government agency, there is an opportunity for service upgrades, you will always get more than you can deliver at one time. So I might ask the CEO to describe and the Chief Operating Officer to respond. But that is broadly the process that is being followed.

I have already told the committee about the service improvements that have happened but there are more to come.

Dr ALCORN - The Mersey is a major focus of what we are going to be doing there, and that includes the rehabilitation, palliative care, as well as more outpatients in the Mersey. So we know what work we are going to be doing there in some detail, but as the minister indicated we have had some very good business cases. What we also want to do though is make sure that we are able to utilise all the expertise around the state. So for example, one we are looking at quite closely is an allergy service which would also involve TeleHealth.

But there are many opportunities and we just need to make sure that we are giving the best value and consulting with the communities about what they want.

Mr FERGUSON – Deputy Chair, one example of the service increase that has been articulated in the white paper is for endocrinology in the Launceston and the north-western area. Underserved for many years and that is a function both of, I suppose, government priorities of the past, but secondly of availability of workforce. So we have moved ahead of worrying about a specific business case and actually made it clear, right, we are now recruiting and testing the market for that.

It has sadly been not a fruitful exercise so far, but we are still actively engaged in that market place and the labour market. In the meantime, even though there is a hesitance to what to employ more locums, the government policy that I have given to the THS is that I would rather that we were offering a service, even if it is a locum service, to the northern community while we are recruiting and that is, for me and for the government, we feel that that is the right approach where the other alternative is to continue to have an inadequate service.

DEPUTY CHAIR – The perfect segue into this, the issue of locums. It has been a constant battle for as long as I can remember on the north coast, right across Mersey and Burnie. Can you give us the updated figures, and then I would also appreciate a breakdown as to what speciality areas the locums that have been engaged, what their speciality is.

Mr FERGUSON - The last part of your question will be difficult to answer because it happens across the system in every discipline when somebody is on leave and cannot be easily replaced by a colleague or the service cannot go on without them, but I will certainly provide the committee with the data as to cost. I was asked in the other estimates committee for a head count for example, and we simply do not have that.

DEPUTY CHAIR – A head count in terms of?

Mr FERGUSON - Number of people employed as locums because, of course, it is a casual system of employment. I do not have that number. So would you like the full year figures or the year-to-date 31 March?

DEPUTY CHAIR – Have you got the last two years?

Mr FERGUSON - Yes.

DEPUTY CHAIR – Yes, the last two years and the year-to-date. And if you have got an expected final cost which you may or may not have.

Mr FERGUSON - I do have that. I can give you that immediately. So the predicted forecast full year spend on locums in Tasmania for 2016-17 is $27.75 million. So that is what the numbers will add up to.

DEPUTY CHAIR – That is the full year for this year?

Mr FERGUSON - That is the forecast.

DEPUTY CHAIR – The forecast, yes.

Mr FERGUSON - For the full financial year. But of course, if you want real numbers and I know that you do, as actual expenditure as accounted, so to 31 March for the state, $20.758 million to 31 March 2017 to 31 March 2016, it was $17.54 million. If you would also care to take the full year for 2015-16, $23.73 million.

DEPUTY CHAIR – They are significant increases, aren't they minister?

Mr FERGUSON - There are increases there and -

DEPUTY CHAIR – Do you have a regional breakdown?

Mr FERGUSON - I do. The increases are in each region other than the south. So to 31 March I can provide you with 31 March and each previous 31 March.

DEPUTY CHAIR – Yes.

Mr FERGUSON - So for the south – shall I just put it this way, last year, this year, but in all cases it will be 31 March?

DEPUTY CHAIR – Yes, all right.

Mr FERGUSON - So last year south, $1.488 million. This year, $0.996 million. So north, $3.45 million last year. This year $6.6 million. For North West last year $12.6 million. This year $13.141 million.

DEPUTY CHAIR – Do you have the expected projected amount for the North West and the north?

Mr FERGUSON - I can provide that to you but I do not have it in this brief, because it is always asked so we always provide the forecast I have. I do not have a regional breakdown of forecast. I suggest that it would be a reasonable equal ratio of the previous to 31 March date, but I can take that on notice and we can provide that to you.

DEPUTY CHAIR – It is interesting that it really does continue to climb. This has been an ongoing situation. It is not like it is suddenly arisen that we need to engage locums in the north and north-west. So you might have all the detail here, the key positions are they physicians, are they anaesthetist, are they emergency specialists, are they surgeon, general-surgeon, orthopaedic surgeons? I know they are not neurosurgeons. So what are they?

Mr FERGUSON - I will speak broadly first and I have advisors who can speak more specifically about the discipline areas where we are experiencing that shortage in workforce availability. So I want to make it really clear to the committee that we, as a government, reluctantly but nonetheless continue to fund locum employment on the basis that while it is a cost to be always minimised, it is better for our state for services to continue to offered in a safe way, even wearing the additional expense that a locum will cost.

I also invite the committee to reflect that if you were able to fully eliminate all locum use, which is of course impractical.

DEPUTY CHAIR - But you never will. No.

Mr FERGUSON - But if you were to do that, you would still wear a significant portion of the same cost on your permanent staff specialists.

Mr VALENTINE - Overheads and stuff.

DEPUTY CHAIR – It is their on costs, yes.

Mr FERGUSON - To replace a locum you obviously still have to pay so -

DEPUTY CHAIR – Not quite as much though.

Mr FERGUSON - Not as much, but it needs to be factored into the thinking. So we want to reduce the expenditure on local costs, but we have made, as previous health ministers would have said the same, we have made the decision that we would rather continue a service under the more expensive approach to sustain a service that can be safely delivered than end the service.

So the reduction in medical locum costs continues to be a focus. THS has implemented a number of strategies in an effort to reduce locum costs, and there have been some successes which we will shortly point to. The strategies include offering permanent placements to long-term locums and recruiting permanent medical staff, reviewing rosters to reduce very short locum contracts wherever possible, offering additional shifts to current employees to cover vacant shifts in other areas of the state. We have had targeted campaigns through specialist recruitment agencies, and reviewing the medical workforce and models of care to ensure the workforce is best suited to meet the needs of the community and can be resourced on an ongoing basis.

So perhaps in what I am about to share with you might actually start to highlight some of the areas where we have found it difficult, but nonetheless there has been an effort with some success. Now in the north-west where we have had the greatest area of concern for a long time, the THS, at least in the time I have been minister, I think it was approximately two years ago, recruited Dr Rob Pegram who serves as the Director of Medical Services. He was appointed, in fact, I am told last year, and he has commenced working on the strategic recruitment of permanent doctors.

Since his appointment a number of significant vacancies have been filled which will see locum usage reduced over the next six months. So these include two paediatric positions in the north west. One position in obstetrics and gynaecologist in the north-west with a further two positions offered and accepted by applicants.

DEPUTY CHAIR – So we are going to have three up there?

Mr FERGUSON - I believe the number may even be a little higher than that.

DEPUTY CHAIR – We have never had that before in all my time there.

Mr FERGUSON - That is right. As I would not have to tell you, this was one of the weaknesses of the previous maternity model across the two inpatient sites. So that is -

DEPUTY CHAIR – That is why I have been out behind you on that. You know that.

Mr FERGUSON - I appreciate that. And Mr Gaffney as well. You have been extremely, I have to say, responsible and courageous in doing so because we did it believing it was best for mums and bubs. Not everybody is fully persuaded in the community, but I believe over time we will be able to demonstrate the benefits of a safer model.

So that is great news in obstetrics and gynaecology, so as I say, one is in place and a further two positions offered and accepted. Two staff specialist positions in anaesthetics in the North West have been offered to and accepted by applicants. My advice is that those are expected to commence in October and are relocating from overseas.

4.5 FTE appointed at the Mersey Community Hospital emergency department. One of these positions has now commenced, with the remainder expected to commence over the next six months.

DEPUTY CHAIR – So these are people who have been appointed, 4.5 medical specialists at the DEM?

Mr FERGUSON - These are vacancies that have been filled.

DEPUTY CHAIR – My medical staff, we are talking?

Mr FERGUSON - Yes. I am only responding to medical locum. So one of these positions has commenced with the remainder expected to commence over the next six months. Anecdotally I am told by senior staff on the north- west that the long term securing arrangements for the Mersey has actually brought a new sense of confidence to people to take on longer-term positions.

DEPUTY CHAIR – So in the DEM then, is that the full quota, 4.5 FTE? Or are we still short there?

Dr ALCORN - Some are still coming, as the minister said. So one has started and the remainder are still coming.

DEPUTY CHAIR – But will the 4.5 be the full quota?

Dr ALCORN - We will still have an ongoing reliance on ED locums, but we are using more career medical officers and rural medical officers, including local GPs.

Mr FERGUSON - Ms Forrest's question was however, if we have achieved 4.5 FTE at the Mersey, we may need to take this on notice, how far does that get us into replacing locums?

DEPUTY CHAIR - A sustainable, yes.

Dr ALCORN - We would need to take on notice.

Mr FERGUSON - So a career medical officer commenced in January this year with North West Mental Health Services and a further two specialists have been appointed. Both are relocating from the UK and expected to commence in December this year. A gastroenterology staff specialist also commenced in the North West in January 2017. Two consultants have been appointed in mental health services at the LGH, both are however pending after registration.

LGH emergency department registrars are due to commence in October and a further two consultant applicants are currently being considered. So what I would like to say to you, Madam Chair, is that apart from all of the other efforts that I could continue to speak about, and the CEO and the Chief Operating Officer could continue to speak about, I think that the people of Tasmania and especially the north west, through me, can express a lot of gratitude to Dr Pegram for his work. He has been an exceptional leader in this space and has actually brought, I think, a fresh approach to this recruitment challenge, and while we are not seeing the benefits of the work in the numbers before the committee today.

DEPUTY CHAIR – No, you won't. Hopefully next year you will.

Mr FERGUSON - I hope and expect that that will continue to turn up in future estimates committees of the savings to the state on locums. But to make a broader point, a better service, staffed by people who are committed to the region and -

DEPUTY CHAIR – We know better patient outcomes occur from better continuity of care.

Mr FERGUSON - That is right.

DEPUTY CHAIR – There are a couple of areas that you did not touch on unless I missed them, minister, and correct me if I did. The Department of Emergency Medicine at the Burnie Hospital.

Mr FERGUSON - I am not aware of any more appointments. I have outlined the successes in the North West.

DEPUTY CHAIR – Successes are good to hear about, minister.

Mr FERGUSON - That is not to cover any remaining areas of challenge.

DEPUTY CHAIR – So can we have an idea of the need at the DEM at the North West Regional Hospital Burnie?

Mr FERGUSON - So we have already undertaken to provide that for the Mersey. I will do that also for the North West Regional.

DEPUTY CHAIR – And ICU, obviously only at Burnie. Do we still have some challenges there?

Mr FERGUSON - My officials can speak to that.

Dr ALCORN - We have been successful in recruiting two ICU specialists who will do week about and we are seeking a further.

DEPUTY CHAIR – So anaesthetists - are we at -

Dr ALCORN - ICU specialists.

DEPUTY CHAIR – No, I am talking about – I understand that. So anaesthetists, both at the Mersey and North West Regional, are we still struggling to meet the demand there?

Dr ALCORN - Yes, we are still looking for more anaesthetists positions but the Minister explained, we have two anaesthetists coming.

DEPUTY CHAIR – Will that fill the gap?

Dr ALCORN - We will have to research that for you, Ms Forrest.

Mr FERGUSON - I wonder if we can make this a practical response that we can generate. We will provide the committee with a broader view of the areas of speciality where we still have locum reliance.

DEPUTY CHAIR – That is right, where the gaps still are. Pleased to have included the successes, where those have been recruited but that is only one half of the story.

Mr WATSON - I will just state the answer. At any point in time, we have a number of vacant positions. Some might be being supported by locums and some might not. Perhaps the clearer and simpler would be to simply identify the vacancies in respect of whether we have a locum in them at the time, because then we have to go and hunt down, have we got a locum. That is acceptable, minister.

DEPUTY CHAIR – Unfilled positions is what I am asking about.

Mr FERGUSON - I will undertake to provide for you a useful plain English assessment of the areas of need where we have traditionally relied on locums. Nothing of course, that some of the positions that I have identified as having been positions offered and accepted, there are expended commencement dates a little later in the year, and as happens in this portfolio, at times people have been offered and accepted, positions and then not – they might reneg.

DEPUTY CHAIR – One of them passed away on year that I know of, before they came.

Mr FERGUSON - So these are never guarantees, but they are an indication of the effort that has been going in and our THS officials understand perfectly that I have praised Dr Pegram and set his work out as a model for the rest of the state to follow.

DEPUTY CHAIR – What has he been doing differently, minister, then that has actually been able to attract these – obviously there is this – there is security around having a safer system in some respects, because when you have got that critical mass of patients you've got (indistinct) and you are not doing a one-on-one all the time, then that is much more attractive obviously. But what else has he done that has been different?

Mr FERGUSON - Two things that people at this table and the government can take credit for is the white paper which was to your point on safer services, and that has been particularly out to me by local staff as the game changer for the LNG in particular, because it is a safer model and it is a safer service with the right volumes. The securing the Mersey I am advised is a shot of confidence for that hospital and its staff profile, but -

DEPUTY CHAIR – Attracting married couples that are both specialists also helps. We have done a bit of that up there.

Mr FERGUSON - As a matter of fact, that is something that has been actively within the rules, it has been actively pursued as well with mixed success. But also Dr Pegram has understood that as a government priority we wanted to reduce the reliance on locums, even though there is a financial element to it, the main goal is for a safer model and safer higher quality care by having staff who have to maintain that continuity of care.

Dr ALCORN - I would add, interpersonally he is very warm. He is very experienced. He knows a great deal of specialists all around Australia through having worked in New South Wales and he projects and indeed practises a high level of medical administration services so people, when they enquire, when they agree to come, have a high level of assurance that they are coming to a safe area.

DEPUTY CHAIR – Just on the other side of the staffing costs that can blow out, is the use of agency nurses. Have you got figures on the use of agency nurses across the THS?

Mr FERGUSON - What I have here is again, figures to 31 March. For the south - this is in – so $652 000 for the south.

DEPUTY CHAIR – That's hours, what is the measure?

Mr FERGUSON - Dollars. I do not have FTE or head count. Nurse locum costs south to 31 March, $652 035; north, $683 315; for north-west, $2 261 211. I do not know if I have a forecast for that.

DEPUTY CHAIR – So figures from last year then, minister for the same period?

Mr FERGUSON - I do not have a forecast for nurse locum, agency nurse costs. They are nine month figures that I have provided you with. The full year adds up to $3 596 561 to 31 March 2017, $3.6 million.

DEPUTY CHAIR – Most are in the north-west.

Mr FERGUSON - To 31, it is, true. And last year I have a full year figure of $2 045 882.

DEPUTY CHAIR – Full year. So we are seeing a significant increase there then too, minister.

Mr FERGUSON - So I do have some information here. I think I will ask to be able to add to this answer later and get some more advice. The increase in nursing locum costs in the North West has been largely driven by 1, 2, 3, 4, 5 factors. First, the North West Rehabilitation Unit Employees has had fixed term vacancies cross other units. The April 2017 decision to permanently establish the rehabilitation unit will allow for permanent recruitment and is expected to reduce the use of locum nurses.

Second, an inability to attract and retain nurses despite several attempts to vacancies. Three, recruitment to the North West Regional Hospital Critical Care and Emergency Departments has improved recently and it is expected that a drop in agency nurses will occur. Four, Mersey has a number of hard to fill vacancies requiring significant recruitment efforts.

DEPUTY CHAIR – The Mersey does?

Mr FERGUSON - The Mersey.

DEPUTY CHAIR - In what area, do we know?

Mr FERGUSON - I will just come back to that. Additionally, a number of very experienced employees have retired which requires appropriately skilled replacement. And five, it is expected the certainty provided with the recent Mersey funding arrangements with assist in permanently recruiting two vacancies. I am advised the Emergency Department has been hard to fill.

DEPUTY CHAIR – Minister, I think you will be well aware of the aging demographic. What is the average age of nurses in the state?

Mr FERGUSON - That would be a question I would need to take on notice and seek that advice from our Chief Nurse and Midwifery Officer.

DEPUTY CHAIR – Because it is relevant. If you have people retiring, you are going to face this problem again.

Mr FERGUSON - While I will provide you with that information, the opportunity for graduate nurses has never been better and that is why we have gone to a special effort of working with the university to ask it to make sure it is understood amongst its graduate nurse cohort that they are job opportunities at the moment and it adds to what the government was already doing by increasing the number of graduate nurse positions for transition to practice by 85 over the period of the parliament. So that is in place, and I believe at this point has been fully delivered but nonetheless, there are opportunities and we would love to engage with younger, less experienced nurses to be part of the team. Obviously with the right mix, so that we get the right balance of experience and supervision.

DEPUTY CHAIR – I accept that there is cost with a permanently employed nurse as well. So these additional costs for agency are only part of the picture, and one of the reasons you gave for the additional requirement for agency nurses was with the rehab unit. So casual nurses couldn't have been employed in that? You had to use agency. And how much does it actually contribute to the additional cost above and beyond. The agency nurse is a cost yes, but not all of it would go away, as you said with a locum. So do you have an idea about how much it is above and beyond?

Mr FERGUSON - I don't. I am happy to also obtain that for you, noting that somewhat anecdotally the differential between an award or EBA paid permanent doctor compared to a locum doctor is a far better factor of difference than between an award paid nurse and an agency nurse.

DEPUTY CHAIR – Trust me, I understand that.

Mr FERGUSON - I am not sure how much of that would be avoided or defrayed by it, but I will obtain that for you. So we have some proportion for you to be aware of.

DEPUTY CHAIR – Anyway, we are seeing a significant -

Mr FERGUSON - So what we will do here is have a look at everything that has been discussed in the Hansard and we will just attempt to provide the committee with a more of a considered response to a range of the issues raised so that we can give the committee a sort of understanding that I can sense you are looking for.

DEPUTY CHAIR – I think Rob has a follow up question.

Mr VALENTINE - It was just with regard to nursing recruitment. Are you also working with the TAFE college with regard to enrolled nurses. Is there a part that enrolled nurses can play to ease the load? I know they need to have a registered nurse, I think, supervise them.

Mr FERGUSON - The answer is an absolute, yes. There is a genuine and important place for enrolled nurses as part of THS staffing. And it is a delight as I go about, particularly some of the subacute hospitals that you visit. You will inevitably bump into an enrolled nurse and going a fabulous job, so there is absolutely a place for that. There has even been a place for enrolled nursing in our election commitment to provide more opportunities for transition to practice. So that is strongly supported by the Chief Nurse might I add, Francine Dowse and the THS and the department do work closely with TasTAFE as the major trainer of enrolled nursing graduates.

Mr VALENTINE - So that goes to my other question which I sort of alluded to in the previous session. Where do the recruits go? So presumably the TAFE training, is that happening in other areas of the state and are they able to stay in there region, the ones that are training through the TAFE system, are they able to be employed in the North West and in the north and east coast, I suppose for that matter?

Mr FERGUSON - I am not sure that we have the best person at the table to provide that detailed advice but broadly, yes, because the TAFE, I can't tell you specifically where the training occurs because I know only of it certainly happening in my part of Tasmania in the north. I know that enrolled nursing training is provided there. I do not know but I suspect it is provided in other regions also.

Mr VALENTINE - What about the recruits that are coming out of the UTAS. Are they going to all corners of the state? Have you got a split on that? Say over the last year?

Mr FERGUSON - I am not sure I could align recruitment with where they were trained on campus. You would be well aware of nursing graduates from Hobart. We also have a nursing school in Launceston so we are actually training north and south. There is an element, I am advised, of training that occurs at the Cradle Campus as well but need to check that.

DEPUTY CHAIR - Not much. They mostly go to Launceston. They have their interactive lab there, which is a fantastic facility at the university. Admitted Services?

Mr FARRELL - No, more general to Chester.

Mr VALENTINE - I have questions.

DEPUTY CHAIR - You go. Yes, that's all right.

Mr FARRELL - Minister, when we debated reducing the THS down to one, we were told that there would be, I think it was around $21 million in savings through efficiencies. Do you have any details to date that would illustrate what the dollar savings have been in the efficiencies? Just so we can judge whether we did the right thing or not.

Mr FERGUSON - I want to assure you that I think we did, and I thank you and your support that has been on display during that process, and I can give you some insight into the savings that have arisen from the consolidation, and I am part of a Government, and thankful for it, that made the decision that whatever happened with the consolidation, any savings would not be taken out of the organisation as saving. It would be preserved within the organisation.

So in the THS, of course, as you know, was established on 1 July 2015. It has a single governing council, a chair and skills-based members. Incidentally, it has a spread of regional representation, a single CEO supported by an executive, and also now increasingly meshing into an evolved leadership model at the local level also. It has never been a black and white, it has never been a State versus local paradigm. It has been about what is the right balance.

So the THS is progressing the establishment of a single statewide delivery structure designed to improve the coordination of services and reduce duplication. Key objectives continue to be implementing our statewide Health Service that sees patients receive the right care at the right time and the right place, with the structure in place, freeing up funds and redirecting them to frontline service delivery, and ensuring care is provided where it can be done safely and efficiently.

To date, the THS estimates accumulated savings in administration and corporate services of $4.1 million that we are able to broadly point to, shared services and procurement of $9.3 million and standardised and improved revenue practices of $1.0 million, and of course as you would rightly expect us to, the Department and the THS will continue to look for opportunities to identify savings and efficiencies in the delivery of Health Services and invest those savings in the delivery of frontline services. Would you like more detail?

Mr FARRELL - Is it possible to get -

DEPUTY CHAIR - You could table it.

Mr FARRELL - Table it, yes. If that is tabled that would be great, and if it includes the number of admin and clerical staff before and after, just to show the progress through the efficiencies gained it would be very good if we could get that.

DEPUTY CHAIR - Do you have it in that sort of format, minister?

Mr FERGUSON - I will provide that table. I have got a table that includes renegotiation of electricity contracts, energy efficiency initiatives, statewide vehicle savings, absorption of salary increases, paper contract cost reductions, tender cost reductions, procurement savings, admin and corporate positions and improved revenue practices. So I will have that table provided to the Committee with a number of footnotes.

DEPUTY CHAIR - Today you will do that?

Mr FERGUSON - Yes.

DEPUTY CHAIR - All right. Thank you. Craig, would you -

Mr FARRELL - I am happy to let others roll on.

DEPUTY CHAIR - We are sort of in 1.1, Admitted Services, at the moment, so it is sort of broad, but -

Mr VALENTINE - Yes, just about the number of acting positions in the system at the moment in the various acute -

DEPUTY CHAIR - Just wait until he comes back with table.

Mr VALENTINE - Sorry, minister, I should have been more polite. I am a pusillanimous person. With respect to the number of acting positions that there are in the major acute hospitals, can you give us some idea of that?

Mr FERGUSON - Of what positions?

Mr VALENTINE - The acting positions. People that are acting up into a role because somebody has left or there's nobody to fill that spot and, of course, that has a waterfall effect, I suppose, if I could say, and that can cause issues in terms of management and the like, so do you have any information on that/

Mr FERGUSON - I am pretty aware of what is in my briefs because I have read them many times. I do not have a number to share with you, but I will invite the Chief Operating Officer or the CEO to add to what I have to say and I am just going to provide you with some overview comments now.

The organisation is still maturing. We have moved to the single organisation structure, just now short of two years. We have spent much of that time building the Executive, the statewide Executive. That has certainly been an exercise where we have needed to patiently recruit and get the right people in the right in the right positions. We now have a full complement of the THS Executive and with the final substantive appointment being the recent appointment of the Executive Director of Human Resources.

Throughout all of that time we have always made it really clear that it was not, as I shared with Mr Farrell, it is not a binary choice between statewide control or local autonomy. It is actually about getting our One Health System thinking in line with the practicalities of local management, and so we are moving to a new model which I can just touch on briefly before we go to the acting - the level of acting arrangements, yes. I don't think we have a statistic but we will certainly give you any detail that we can reasonably take on notice.

So we want the Health System to function effectively as one. There are clear benefits in allowing operational decisions to be made on the ground by those who best understand operational demands that are happening under the roof of a single hospital structure. Getting both statewide and local leadership structures working seamlessly is the key. To achieve this, we are proposing to establish Executive Directors for the south and north, north-west supported by operations managers at then each of the four major hospitals.

So support these positions, we will also be appointing clinical and nursing directors to provide expert advice in key areas at the hospital level, and to be part of the hospital management process. Even though this is where we have broadly landed, it has taken - I said to the other Estimates Committee earlier this week, I expressed an element of desire that this had happened earlier, but the reason it's taken longer than anybody would have really wanted is because we have been consulting

and we wanted to get the model right and get the best of everybody's good will, and so we are currently in a period of a two-week window to do one final round of consultation on this model which I think does demonstrate building strong and effective local management while not walking away from the mandate that we all have actually to deliver a health system that works for the whole State, recognising that despite good intentions, the regional structure didn't really deliver for our State.

So on the acting, there are a number of positions where ether are acting positions on the basis of waiting for the final clinical Government structure to be outlined, and so there has been an element of anticipation of the final model, and in that context there are a number of positions around the State, and in your neck of the woods at the Royal, where you have had an acting arrangement in place. So Chief Executive, could you add to what I have said in terms of senior positions in local hospitals that would be acting at the present or that we would be pending the final consultation on this, then ready to formally recruit to?

Dr ALCORN - Yes, in Hobart there are a number of substantive nurse positions that are able to be a line state across, but there will be medical positions where there have been actors or there has been vacancies we will fill.

Mr VALENTINE - How much impact do you think that is have on the overall efficiency of the service? Is that something you can comment on? Is it a real pinch point for you or not? Is that a problem, the fact that you have got -

Dr ALCORN - Would it be helpful to your question if we talked about the Royal, for example?

Mr VALENTINE - If you wish. I am thinking statewide, but if you want to talk about the Royal, by all means, talk about the Royal, but I am just interested in the overall impact of not being able to fill positions that may well be very important positions, but because other people are filling them, may not have the total, like, corporate knowledge or indeed may not have the expertise to be able to fully function in those positions.

Dr ALCORN - Yes, look, I don't think it's a question of day-to-day functioning. It is more the longer term planning that takes place when there is a substantive leader. People who have been acting have been working very hard and very well with our local managers.

Mr VALENTINE - Have you got any union problems in there at all that you are dealing with?

Dr ALCORN - In relation to acting positions?

Mr VALENTINE - In relation to the fact that people are acting and positions aren't being filled and whether there are any industrial issues that are arising out of that, that are of any major concern?

Dr ALCORN - Not that I am aware of, no. We have regular contacts, and in fact I was with the unions yesterday. We have regular contacts with them and they have plenty of opportunity to raise concerns.

Mr FERGUSON - That doesn't mean, Mr Valentine, that there are not union issues, and there are many that raised from time to time.

Mr VALENTINE - I am sure they are, but I am just wondering how critical they are. That is really the question I am getting to.

Mr FERGUSON - And I don't mind saying to this Committee and to you, the Government's role in this is to see the best in what people have to offer, to, at times, be the perhaps play a little bit of a mediating role when Executive management and unions are not seeing eye to eye, and we do that - we play that role delicately and often in the background, and I play that role, and we have got a big task in front of us. I believe there is a lot of good will, despite some of the things that are said outspoken politically by stakeholder groups. There is still a lot of good will, and one thing that I am very grateful for is, even in the midst of some strong statements that have been offered, people in those stakeholder groups do make a really strong point to me, and they say, "We still strongly support One Health, and we want to get on and make this work", and to that end, I ask, and I have, and our focus is now, we need to stand up these beds.

We need to staff them, allow patients to have better patient acute bed access and ensure that we can provide a more timely service. There are significant job opportunities now, and we are putting some closure around the State's clinical government structure. I think it is giving everybody, all players concerned, a greater sense of what the future looks like and how they can fit into it, and I just really welcome that, and I think that it gives us a pretty solid foundation to get on and address some of these systemic issues that this State has been grappling with for decades.

Mr VALENTINE - I can understand the role the THS is playing in terms of bringing the State together. Each of the major acute hospitals can, if you like, they are almost their own fiefdoms, and that has been historic over a long period of time. Are you making any inroads into that? Are you stopping parochialism? And don't laugh at me, but it is a question. Are you able to overcome some of those barriers and really get a proper, well-functioning, integrate service across the State happening? That is really a broad question, I understand that, but I would really like some understanding -

DEPUTY CHAIR - A succinct answer would be good.

Mr FERGUSON - And I promise you never to laugh at a question like that. It is actually a deep and important question, and it's one that I still don't believe we have adequately set aside as a problem for our State, including the Health system, but I genuinely believe we have made real progress, but there can be no doubt, if I am just speaking openly with you, I still believe that there is an element of that. There is still an element of that fiefdom, as you described, in our hospitals, but there are many good people who really do want to improve the system for the State for our patient consumer community, and I think that there's enough goodwill in there for us to continue to make progress.

Mr VALENTINE - So it's been suggested, it is a suggestion, it has to be asked, I suppose. The THS is actually trying to do its job. Is there any ministerial interference in there anywhere with regard to not allowing code yellows to happen and those sorts of things? Can you cover off on that? Because there have been some suggestions that that is the case.

Mr FERGUSON - Yes, and I welcome the question, actually, because I would kind of rather that you did ask it and allow me to say that I have no role in the calling of any code, yellow, brown, blue, black, red.

DEPUTY CHAIR - Let's hope you're not referring to a purple.

Mr VALENTINE - Or giving a direction that says, 'I don't want them called'.

Mr FERGUSON - I will be thoroughly truthful and comprehensive with you on this. Nobody wants to have a code called that is not appropriate in the circumstances and that includes myself, and I have given, and I don't interfere with the THS, but I work on a day-to-day basis with the THS Executive and the CEO, and I also work on a day-to-day basis with the Secretary in the Health Department, and that is my job and I willingly intervene at appropriate junctures and have done on numerous occasions and will continue to do so where I believe that a new call needs to be made on a particular issue or measure.

One I can point to was the car parking arrangements at the Repat Hospital around the Little Ward, you know? Good people in our THS working on doing things differently and better, well-intentioned, and there was an occasion where I felt the need to intervene.

DEPUTY CHAIR - But you don't interfere in clinical management?

Mr FERGUSON - But I do it judiciously.

Mr VALENTINE - It is a facilitating roles, isn't it?

Mr FERGUSON - At times. Sometimes I take a lead. At times, many more times I will facilitate, and when it comes to the clinical matters, and certainly in the calling of codes, I play zero - I play no role other than to ensure and make it clear to the THS, as I have on numerous occasions, that what I want to see and what our Government policy is, is an evidence-based and robust escalation protocol that deliveries what our staff need, that is, more tools in their toolkit to be able to assist patient flow during periods of high demand.

At the moment, and we discussed this one year ago at this Estimate here in this room, I described that one of the initiatives that we had included in patients first was an evidence-based escalation policy that staff can use, and it should never have gone political. It should never have ever been raised as a political arguing point because it was - because the whole point of escalation protocols is to help the staff to help their patients, and one of the pieces of work was not just putting in place the escalation policy, which is Levels 1, 2 and 3, with an avenue potentially to a Code Yellow, but we made it very clear that we wanted to refine that, to ensure that we have an escalation policy that is actually evidence-based.

There has been a lot of talk about Code Yellows in the last few weeks because that's kind of been raised in my House at Parliament, in Question Time, for example, and I don't think it serves the public for the shadow minister to be challenging the minister on code yellows or alleging that either the minister approves them or vetoes them, and I never have and I never will. It is entirely a decision for the organisation to manage.

The only observation I will just make is that code yellows, as I understand them, are not intended for patient flow. Code yellows are intended for the one time which I'm aware were where the telephones went down. For the occasional times where there might be an asset breakdown in a hospital that requires everybody to work together and fix something -

Mr VALENTINE - There was one in today's paper, in fact, that was alluded to in Paediatric Services where the Norovirus that is just hitting, and so that was a potential code yellow, but it has been downgraded to a Level 2 or something.

Mr FERGUSON - Just on that, my advice is that that is not a code yellow, but it is an illustration of a situation where the hospital wanted to communicate that they needed to take infection control measures in a hospital, but it wasn't specifically related to patient flow issues. That is, patient in the waiting room being able to access the ED; the person in the ED who is ready can be admitted to a ward, and the person who is on the ward who is ready to go home, to go home, so that is patient flow.

In Escalation Levels 1, 2 and 3, which we currently have in place, I am advised these things are intended to be increased in level of escalation to allow new measures to be implemented there and then to keep that flow moving, and it may involve bringing in additional staff. It might involve asking doctors to come in on the weekend to discharge their patients who are safe to go home, who otherwise would have been waiting for a discharge on Monday.

DEPUTY CHAIR - Minister, you are right here. We need to move on. We have a lot to get through.

Mr VALENTINE - So I guess my point on this is whether there is enough, not fat in the system, but enough capacity in the system to deal with something like that when it occurs, or are we really up against it?

DEPUTY CHAIR - So patient flow and access to beds and that sort of thing, they are blockage, that sort of thing we are talking about now? This is not code yellows.

Mr VALENTINE - Not, but when code yellows occur, people have to come in from other places where they are stationed to be able to deal with that.

DEPUTY CHAIR - It depends why the code has been called, but anyway, yes.

Mr FERGUSON - Because you ask me a question, I just feel the need to explain, given account of myself. I don't veto code yellows; I never have in three years of being minister.

Mr VALENTINE - No, you told us that. I appreciate that.

Mr FERGUSON - I certainly don't approve of them, but what I do support is the organisation to continue to refine its protocols so that it is evidence-based and it really will actually help the staff, because they at times do feel that they are not providing the best and most timely care to patients, and I support them in getting those tools.

Mr VALENTINE - And we don't want it to be implied. That is the difficult part. Thank you.

DEPUTY CHAIR - Yes, so can we go to a question I had on this line in considering those comments you have just made. Bed block has been a challenge in the past. Part of that is because of inefficient discharge practices, some of it has been lack of beds in aged care facilities or an unwillingness, perhaps of some patients to discharge to our regional hospitals. Is bed block still a problem and for this? What are your key drivers for that?

Mr FERGUSON - The Chief Executive can add to my answer, but the key drivers would include increased demand for Emergency Department access through the EDs themselves. We have got, and I just touched on this during my discussion on escalation policy, there is the need for additional measures to allow people to be discharged in a safe way but perhaps a more timely way, and the Chief Executive, I think, will reflect in his answer some of the reasons for the increase in demand, I think does reflect the age profile of our population and some of the complexities -

DEPUTY CHAIR - So it still is an issue, bed blockage?

Mr FERGUSON - It is an issue, and I think this is exactly why the Government wants to support the Health System, more beds, and of course, more beds is not really more beds, it is more staff providing more care in more beds.

Mr VALENTINE - To make the whole thing work.

Mr FERGUSON - Which is what this budget really is all about for us. So the factors on patient flow?

Dr ALCORN - Yes, the comment made previously about aging of the population and multiple co-morbidities, it means that there are patients who require to come into hospital the day before for their surgery. They may have more complexities that would prevent them from being operated on as a day surgery patient which is obviously highly desirable if we can do that.

We also face a demand on our Intensive Care Unit services which also limits the freedom by which we can discharge people back into the wards, and we do know that there are cyclical surges around 'flu season which also burdens us and burdens the excess block issues.

DEPUTY CHAIR - To move on from that, do you have the, to give a bit of context, I guess, the total numbers of nursing, midwifery, FTEs across, by region, nurses and midwives, yes? If you could provide that, and also a cross-classification of whether they are working in Family and Child Health or Palliative Care, what level of detail you go to, but I just want to know the actual staffing levels at the moment. If it was a table document I think I could seam this, maybe it is better to table that as opposed to reading it all in if that's possible.

Mr FERGUSON - I will just find it first.

DEPUTY CHAIR - While you are looking for that, I will say I am not interested in the amount of overtime, and double time, double shifts that are being worked across the regions as well.

Mr FERGUSON - I can provide you the numbers broken down by region, I believe, if it take it on notice and come back to you, for nurses.

DEPUTY CHAIR - That is the total FTEs?

Mr FERGUSON - You asked me for nurses and midwives FTE by region?

DEPUTY CHAIR - Yes.

Mr FERGUSON - But I will need to take that on notice and come back to you.

DEPUTY CHAIR - Have you got the total numbers for the whole State?

Mr FERGUSON - That will add up to that but I don't have that here.

DEPUTY CHAIR - So you will provide that?

Mr FERGUSON - I will. I will provide that today.

DEPUTY CHAIR - Thank you. And the number of double shifts work and the amount of overtime that's been worked.

Mr FERGUSON - Tasmanian Health Service overtime, inclusive of double shifts, by cost in dollars, so what I have for you, and I'm sure you would like to compare it with previous year, so what I have here is full year, 2015-16, $7 332 255.

DEPUTY CHAIR - That is the state you are talking about?

Mr FERGUSON - Yes. Did you ask me for that by - broken down? B - If you have got it as well, yes, I did say by region, but I am happy to have the headline figures first.

The full year 2015-16 overtime, counted by cost, $7 332 255; regional, north-west I do have, regional north-west is 1.041 million; 0.1042 million, to round it correctly; northern 2.974; southern, 3.316; and I don't have a comparator to 31 March for that period, but I do - but that is what I have for this financial year. So by region to 31 March 2017, I have north-west, 1.037; north, 2.422; southern, 2.885.

DEPUTY CHAIR - So clearly, the north-west is going to blow out even further than last year. We have still go that is only nine months of the year, and it is almost up to where it was for the full year last year, if I'm correct.

Mr FERGUSON - It is about $1 million short on the statewide total, so you could -

DEPUTY CHAIR - Yes, but the north-west seems to -

Mr FERGUSON - You could make assessments on that, but the total for the State, as I said, is 6.344 million.

DEPUTY CHAIR - I understand there's often more demand in places like ICU for double shifts and overtime where specialist staff are more difficult to - you can't just move someone off one ward to go to ICU necessarily. Being as we hear about a lot of demand in the Royal's ICU, for example, do you know what attributes to that high level of overtime and double shirts at the North West Regional Hospital, when you consider you have got many more agency nurses, many more locums, and now you have got much more overtime and double shifts being worked in the North West as well. I thought you would be using some of the agency nurses. Surely that would prevent - reduce the need for double shifts.

Mr FERGUSON - Yes, so we certainly all want to, and are seeing, and want to see reduction in double shifts, overtime ideally as well, but the double shifts has been an area of special focus because I think ideally people work an eight-hour shift because that is their shift, but if they are required to work overtime and willing to do so - I should put that more correctly. If they are willing

to do the overtime because they are asked to and they do, I would rather that they did a number of hours extra over time rather than a double shift and that has certainly been the Government policy.

DEPUTY CHAIR - From a patient safety point of view that is pretty important.

Mr FERGUSON - Exactly right. So what we have done, and we have deliberately presented the data so it gives the complete picture by providing the total overtime cost including double shifts. We haven't split it out. Double shifts and presumably overtime in general is highest in areas requiring post-grads, qualified specialist nurses, including in critical care, EDs and psychiatric medicine. This areas are staffed with nurses with specialised skills specific to patients' clinical care and safety. Backfilling in these areas requires the same level of expertise which is not always available at short notice from existing Tasmanian nurses. The services of speciality nurses are also in demand in private hospitals, especially over winter and school holidays. So that is the advice.

Yes, and I am advised that there is - we are never relaxed about this and we shouldn't. We always want to minimise double shifts, but while there is significant work under way to improve overtime levels, double shifts represent approximately 1.3 per cent of total shifts worked by nurses and midwives across the THS, so a very small percentage, but that is not to downplay the issue of double shifts where it does occur.

DEPUTY CHAIR - My concern was that the North West is still seeing a high level of overtime and agency nurses. It just seems to be - I accept that it is difficult to call in specialty nurses at short notice up there, but if you have got a lot of agency nurses, obviously they are being used for that purpose as well, so I think it is only - you actually need to have a closer look at it in trying to put a cap on the cost that perhaps can be avoided.

I just want to go to the contract with the North West Private Hospital for maternity services, the old hoary chestnut that has been well understood for a number of years. Are we making any progress on dealing with this in terms of its longevity?

Mr FERGUSON - Yes, it has been done.

DEPUTY CHAIR - It has been done?

Mr FERGUSON - Yes, this Government did it.

DEPUTY CHAIR - When did that happen?

Mr FERGUSON - They said they couldn't do it.

DEPUTY CHAIR - I know they said - well, many people before you have said they couldn't do it.

Mr FERGUSON - This minister did it with the support of great people in the Department in the THS.

DEPUTY CHAIR - So what have we got now?

Mr FERGUSON - It is no longer an evergreen contract.

Mr VALENTINE - It is worth a few Jaffas, that.

DEPUTY CHAIR - These are worth a few Jaffas.

Mr FERGUSON - It is a bit like Bathurst Street, so not bragging, but it's a great achievement and it is now - their whole contract has been set aside and renegotiated. We now have an eight plus five eight-year contract, time limited with a five year extension that commenced on 1 November last year when it coincided with the new maternity model.

DEPUTY CHAIR - It was convenient, I guess, to do it at time?

Mr FERGUSON - Not just that. It is a game changing -

DEPUTY CHAIR - It is in terms of capping the costs up there, yes.

Mr FERGUSON - Yes, so what would you like to say about that? I will just let you -

DEPUTY CHAIR - More power to you, minister, I say.

Mr FERGUSON - I will just let you say something for the benefit of everybody listening.

DEPUTY CHAIR - In terms of savings, what will the savings be from this?

Mr FERGUSON - It wasn't with a savings agenda in mind.

DEPUTY CHAIR - No, I know it wasn't, but it has been a significant financial burden on that region for the last, how many years? Fifteen?

Mr FERGUSON - Mid-1990s, I think.

DEPUTY CHAIR - Yes, longer than that then.

Mr FERGUSON - I would not like to be - I will need to check, but I think that my recollection at the time was that we actually negotiated a pricing structure which was better than before, if I can put it that way, but it is a different - the new contract is by nature very different as well to the old contract, so -

DEPUTY CHAIR - I accept that, yes.

Mr FERGUSON - And in ways that are very positive. So the new contract started when I said, in November. That was also the end of the evergreen contract. That contract was renegotiated to achieve that outcome as well as greater safety and quality provisions which are now documented, and it supports a cohesive working arrangement between THS and the Private. The Private under took a range of activities required in advance of that commencement, including some capital works. The contract term is eight years now with a five year extension option at the discretion of Government.

There is sufficient capacity to manage the additional activity, and approximately 1 100 births per year are expected with the existing four birth suites anticipated to be sufficient to manage this volume, and also, despite some local suggestions to the contrary, there have been no occasions since

that service change where there has been insufficient birthing capacity. So the contract contains a lot more than that, including sanctions, where performance outcomes are not met. Regular contract management meetings are held between THS and the North West Private Hospital to ensure all of the contractual obligations of both parties are being met and adhered to. Clinical governance is monitored by regular meetings with representatives from THS and the North West Private Hospital in attendance.

DEPUTY CHAIR - The number of born before arrivals, do you have that information or not?

Mr FERGUSON - Sorry, the number of?

DEPUTY CHAIR - Born before arrival. There is commentary around at times that that has increased.

Mr FERGUSON - I would be happy to bring to the Committee my update on that which is very satisfying.

DEPUTY CHAIR - So you can do that now?

Mr FERGUSON - I don't have it here, but I can bring it to the Committee. The number of early births -

DEPUTY CHAIR - Born before they arrive at hospital. I mean early births happen in hospitals.

Mr FERGUSON - Ambulance birth, for example?

DEPUTY CHAIR - Yes, or in the car.

Mr FERGUSON - Yes, I can give you some advice on that. It is absolutely minimal.

DEPUTY CHAIR - It happened before anyway.

Mr FERGUSON - That is right, it did happen before and it will continue to happen.

DEPUTY CHAIR - It will continue to happen. Some babies wait for no one.

Mr FERGUSON - I can think of one that was born in the car park at the LGH.

DEPUTY CHAIR - One of yours?

Mr FERGUSON - With no service chain. Not one of mine. All of mine were -

DEPUTY CHAIR - I have met a few in the car park, don't worry.

Mr FERGUSON - But it has been a great achievement. We modestly proclaim it as a great achievement, but that is because it is a better - it is a safer model. It is safer for mums and it is safer for babies, and I believe in my heart, as I think you do, that over time we will be able to say it has saved lives.

DEPUTY CHAIR - The other positive thing up in the north-west in terms of the Maternity Services is the dental, access to dental care for pregnant women in that service. I did receive an email from some of the managers up there with a lovely story about a woman -

Mr FERGUSON - I asked them to send it to you.

DEPUTY CHAIR - Yes, it was a lovely story that highlights the importance of that service. I did ask your staff up in the north-west region about whether they are working with Menzies or anyone to actually do some research on this because we know that there is plenty of evidence to show that dental care does reduce the rate of premature births, and improve outcomes for babies. So it would be good to look at that. Is that something that you are considering or would consider?

Mr FERGUSON - I would consider it. I do not run the Menzies, but I would be happy to look at the suggestion and support research wherever it is likely to improve the evidence base to better health services.

DEPUTY CHAIR - Yes, there is a social outcome improvement for that woman and other women who are accessing it, as well as the potential outcomes for the babies.

Mr FERGUSON - We are happy to take it forward as a suggestion.

Can I please just share with the Committee some other advice I promised to provide?

DEPUTY CHAIR - Yes.

Mr FERGUSON - I have here Mr Farrell's question on saving estimates since the formation of THS which I will - do I table it, provide it, and I also have - I'm sorry, I can't recall who asked the question, but I was asked for workforce on nursing and midwifery, and what I have to hand at the moment is all ministers and midwives in Tasmania, not just in the Public Service, so this is across the State. This is sourced from the Institute of Health and Welfare.

DEPUTY CHAIR - To the private as well?

Mr FERGUSON - That is the comprehensive view.

DEPUTY CHAIR - So we don't have the - can we get the figures for those employed -

Mr FERGUSON - The average ages that you were asking for?

DEPUTY CHAIR - The average ages are there? All right. Not the numbers, the average age.

Mr FERGUSON - No, but we are still providing you a nurses, midwives regional FTE count.

DEPUTY CHAIR - All right, that is fine. Any other questions from other Members on Admitted Services? Rob, did you have something?

Mr VALENTINE - Just with respect to the pinch point, so you have talked about a couple, I suppose, through our conversations, but are there any real pinch points, from top to bottom in service delivery in the Admitted Services area? Ae there other pinch points that you are coping

with at the moment and trying to resolve? I know, for instance, Diabetes and Endocrine Services are a real, or have been a real issue. Can you maybe comment on that on your way through?

Mr FERGUSON - Maybe we could have this as a conversation if I can fully answer your question then. There are still, I quite your like expression 'pinch point' because it perhaps allows us to talk about those areas where, despite best efforts, it has been difficult to recruit.

Mr VALENTINE - A chain is only as strong as its weakest link.

Mr FERGUSON - There you go.

Mr VALENTINE - It could be cleaners, that you can't find them, and that's stopping theatres being properly cleaned - you know what I am trying to say. So it is that sort of thing.

Mr FERGUSON - The best way I could respond would be by reflecting that in some areas in the THS, and we tend to often focus on the hospital, so I might do that for this conversation. We still experience areas of workforce shortage where it is very difficult to recruit, and so therefore you have a differential in access between a region and another region with a particular specialty, for example, Endocrinology which I have often talked about, or in the north-west, some of the other areas that we have discussed, and that is why we start to then have conversations about temporary staff or locum cover so that we can cover and maintain the service, but that doesn't always fully address the demand issue, and we do see differential which my Government really wants to provide Tasmanians with equal access to the service, wherever it happens to be predominantly based, and so that is why we need to continue our efforts to recruit in the areas of regional shortage. At the same time, whatever the outcome of that, that we have tied up the service as a state so that we are providing better access to it wherever you live, i.e., the King Island example.

Mr VALENTINE - But you not providing a component of service in a more regional location to the detriment that is going to lead to an absolutely acute situation in another region.

Mr FERGUSON - That is a great example.

Mr VALENTINE - Is that what you are saying?

Mr FERGUSON - Yes, close.

Mr VALENTINE - So actively you are dealing with those things obviously on a daily basis?

Mr FERGUSON - The organisation certainly is, the THS, but the earlier example I gave of the person in February from King Island who accessed a specialist appointment in Hobart, you notice how I did say that it saved that person the trip? It is equally possible that the person would never have made the trip at all and been denied access to that service. So that is why our efforts are to step in and build up service where it has been inadequately provided, and local recruitment is one means, but then so of course is the access through video conferencing, or TeleHealth, I should say.

Mr VALENTINE - What would be your most acute pinch point at the moment, aside from beds, if I can put it that way? Aside from beds which obviously is a major, major issue, what is the most acute pinch point for you?

Mr FERGUSON - I think it would show up in those areas where we still see people waiting longer than they should for care, and so -

Mr VALENTINE - What, ED?

Mr FERGUSON - That was going to be the first -

Mr VALENTINE - Going to cover that later?

Mr FERGUSON - Yes.

DEPUTY CHAIR - We will do that then.

Mr FERGUSON - We can cover it whenever you wish.

DEPUTY CHAIR - We will get to that output, yes.

Mr FERGUSON - ED care is not so much a problem, except we have talked about some workforce shortages in the north-west coast, but it is not so much the ED care that is the problem, as the ED itself being able to access ward beds for their patients.

Mr VALENTINE - It is the flow.

Mr FERGUSON - Precisely. So that would be the one, there are no doubt many others, but that is the one that has got the greatest focus through this budget as we seek to open more beds which are in some case acute and other sub-acute, so that we can allow that patient journey to be a smoother and a better one for those who are still waiting at the commencement of that in an ED.

Mr VALENTINE - So do you think you are giving enough attention at the moment to the diabetes and endocrinology issues that you have, as a service?

Mr FERGUSON - As a service, it is absolutely front of mind, and the - not that I want to continue to deflect to the budget, but the budget provides the extra funding for the One Health System service improvements which points to the fact that even if it is difficult to recruit to an area, you still need the resource to be able to hold out the offer, and we want to build up the service provision where it can be safely done.

Mr VALENTINE - Because quite obviously diabetes is something that is escalating.

DEPUTY CHAIR - A non-admitted service.

Mr VALENTINE - Sorry, all right. I am going into another area.

DEPUTY CHAIR - Minister, just to go back to the Admitted Services, can you give us the accrued annual leave of all nursing staff?

Mr FERGUSON - Accrued annual leave?

DEPUTY CHAIR - Yes, and sick leave taken over the last two years if you have got it, or last 12 months to date.

Mr FERGUSON - I can help you there. So for that, and I can give you a bit of an historical context as well. The rate, year ending March 2017 for sick leave for nurses is 5.31 per cent. The previous three years I can give you for context were 2014-15-16, 5.22, 5.27, 5.24, so that's 2014-15-16, so our current rate is very consistent.

DEPUTY CHAIR - It is pretty consistent then. Yes.

Mr FERGUSON - You also asked about workers' compensation.

DEPUTY CHAIR - Accrued annual leave.

Mr FERGUSON - Yes, I can tell you, we don't have that and I will take that on notice.

DEPUTY CHAIR - All right, so workers' compensation would be good to know as well.

Mr FERGUSON - With regard to workers' compensation, I have no break-down on this, and that is perhaps explained by the small numbers, and this is, I think you mentioned stress.

DEPUTY CHAIR - I haven't, but I was going to ask if you had a break-down on whether -

Mr FERGUSON - I thought you did.

DEPUTY CHAIR - The ones that were related to mental -

Mr VALENTINE - That is a good question.

Mr FERGUSON - Let me just give you both. The historical trend, 2014-15, we had 466 claims. This is for the whole workforce, it is not for nursing. I only have the total workforce. So for 2015-16, 458. I will now give you two numbers for current financial year. Year to date, March, 307, and I would like it to not rise above 307, as would you, but if it were to follow the habit of the rest of the year, it would extrapolate to 409 claims.

DEPUTY CHAIR - Do you have the break-down as to whether they are physical claims?

Mr FERGUSON - Yes, because I can only - because I have been provided with the stress-related element of that, which I think answers your question. The historical context is 2014-15, 51 claims.

DEPUTY CHAIR - That is of the 466?

Mr FERGUSON - Yes, a subset of.

DEPUTY CHAIR - Yes.

Mr FERGUSON – 2015-16, 48; 2016-17 to March 37, and I would hope that it doesn't go above 37, but if it were to follow the pattern, that would extrapolate to 49.

DEPUTY CHAIR - So they are pretty consistent as well. Do you have the number of current vacant positions across the THS, nursing and allied health?

Mr FERGUSON - I think it is really related to the earlier question that we had, so if I can just take some advice on that.

DEPUTY CHAIR - We were talking about the medical professionals before.

Mr FERGUSON - I offered to do a more or less overview -

DEPUTY CHAIR - So you will cover that in that?

Mr FERGUSON - -response, didn't I?

DEPUTY CHAIR - You did.

Mr FERGUSON - But you were focusing on the north-west for that discussion. Now you are asking a broader question, I think, about statewide vacancies.

DEPUTY CHAIR - Yes, Mr Valentine was asking about the medical professionals, the doctors, but I am asking about the nursing staff and allied health, so maybe if you could include that information?

Mr FERGUSON - Just so we are clear, I understood Mr Valentine's question to be more about key leadership positions that were acting. Was that right?

Mr VALENTINE - No, it was actually across the whole spectrum.

Mr FERGUSON - Putting those two questions -

Mr VALENTINE - In administration, and also service delivery, yes.

Mr FERGUSON - So if we put those two questions together they are the same question.

DEPUTY CHAIR - Yes, they are.

Mr FERGUSON - And I will attempt to - I don't have that information to hand and I will seek it, and I can't guarantee that I will give it to you, but I will get you what I can.

DEPUTY CHAIR - Another question, nurses are increasingly reporting exposure to verbal and physical violence, and one of the key reasons why some are leaving the profession. Statewide violence principles were released earlier this year, so is there any funding attached to meet zero tolerance to violence strategy? Perhaps while you are getting that information, minister, the question has also been asked by some in the nursing profession is, is there a plan to provide all clinical areas access with swipe cards, as we know we all have around here. You cannot get into this without a swipe card, and many Government buildings are the same.

Dr ALCORN - So in terms of swipe cards, we risk rate all of our areas, and we are in the process of undertaking a review of all barriers with a view to whether or not we need swipe cards. Some areas, we want patients to be able to come and go, and other areas like paediatric wards truly we want to have swipe cards and want them very secure.

DEPUTY CHAIR - It is assessed on an as needs basis? Is that what you are saying?

Dr ALCORN - On a risk rated basis after professional assessment.

DEPUTY CHAIR - The other strategy, zero tolerance to violence strategy?

Dr ALCORN - We have been giving our staff, and we are currently rolling out a new program of responding to workplace aggression and patient aggression towards staff. We have selected a provider and are proceeding to roll that out across the system. As you would expect with three different THOs there were three different systems, and so we will have one system across the service. It is important to note that again the training and the level and depth of that training is risk rated according to the clinical needs of the area so that clearly mental health is going to require a lot more training than an area which is not prone to that level of aggression.

Mr FERGUSON – Deputy Chair, if I could please add to an earlier answer as well, you asked me about double shifts and overtime, so I gave you the, you will recall I gave you the current overtime costs which included double shifts, and you will note that of course it was higher than last year, and that is indicative of the new policy which took effect from January last year to limit the number of maximum number of hours that are worked per shift. When you include double shift data into overtime and get the comprehensive view, you have seen it increase.

However, I really have to also inform the Committee that, because the Government introduced the maximum shift length for nurses' and midwives' policy, which allowed for it to be only done by exception, to limit the number of hours that are per shift, after the first 12 months of that policy in operation, I am pleased to let you know the number of double shifts worked by nurses and midwives fell from 5 092 in 2015, to 4 194 for the same period in 2016, so that was an 18 per cent reduction in double shifts, which is a safer, more satisfactory approach, even noting, as I did earlier, that it accounts for approximately 1.3 per cent of shifts.

DEPUTY CHAIR - One further one on this. Do you have details as to the actual paid leave and professional development taken by nurses during the last 12 months? As you are aware, part of your registration is continuous professional development, so there is a requirement to actually undertake it. Do you have details about that?

Mr FERGUSON - I am not sure how feasible that is to collect that data.

DEPUTY CHAIR - It is not easily accessible? No?

Mr FERGUSON - No, it is not collected in that way, but as you have heard me say many times today, I am wanting to oblige the Committee and if I could be allowed the understanding that I will provide what I can, it may be quite limited, our response.

DEPUTY CHAIR - Yes, and part of this is, in terms of attracting and retaining staff, if it is clear that there are opportunities for professional development that are supported by Government, it makes it a more attractive proposition too, particularly when you have to undertake 20 hours or 40, depending on how many certificates you actually hold. Any questions of other Members? No? One other area I will - Craig?

Mr FARRELL - I am wondering if this is the right area. You covered the issue of the code yellow and the cross-over of responsibilities. It was just mentioned yesterday in Estimates in the

other place that the CEO has access to patient records. Is that, like, a normal sort of a practice? Are there practices you have to go through under the Privacy Act or are patient records able to be accessed by doctors that are not part of that hospital? How does that system work? I was just unclear about the process there, and if you had a non-medical person as your CEO, I imagine that wouldn't be the case.

Mr FERGUSON - Thank you, Mr Farrell, for the question. This was thoroughly answered by myself and the Chief Executive at the other Estimates, and I undertook to get further advice on the matter because in politics sometimes you sense that a leading question might have a leading motive, and I am therefore being extremely careful with getting robust advice, not doing anything other than follow absolute due process which we always undertake to do, and so I would invite you to anticipate my formal response to that House of Assembly Estimates Committee.

Mr FARRELL - Thank you. I thought I would ask it in non-political arena.

Mr FERGUSON - Yes, you did it nicely, but I will just make the gentle and general point that patients' medical records are afforded absolute due process.

Mr FARRELL - Thank you.

Mr VALENTINE - It is fair to say when we were talking earlier about access block, and I suppose over the years it seems to be worsening, and you are addressing some of that. I appreciate that, maybe not to everyone's satisfaction, but I guess it leads to the question of how we are actually measuring upon a national - against the national average, the hospital standardised mortality rates. Can you give us some understanding as to how we are travelling with that? How it may have lessened or grown over, say, the last three years?

Mr FERGUSON - I can, and thank you very much for the question. It is a subject that has been raised with genuine interest lately, and thank you for your observation in your question as well that I am concerned about bed access, because bed access means patient access. So my expert on this, of course, is the Secretary who can speak from a system manager point of view to direct the answer to your question, how are we going with mortality rates, because that is one of a number of measures that is used on a transparent basis to assess -

DEPUTY CHAIR - And I suggest morbidity rates are equally important.

Mr FERGUSON - Yes, but of course I was asked about mortality and I don't want to duck the question, so I will ask the Secretary to give you a very direct and scholarly answer in relation to what that data does tell us, and I will also ask you, Secretary, please to advise Mr Valentine and the Committee about the more recent concerns that were raised in relation to a different dataset and how they are responding to that.

Mr PERVAN - So hospital standardised mortality ratios are statistical indicators that attempt to compare the observed numbers of deaths in a hospital with the expected number of deaths that a hospital displayed the same mortality, if the hospital displayed the same mortality pattern as the national average. They used a screen for potential safety and quality issues in hospitals where high HSMR values should be used as a trigger for us to investigate, to ask questions about the quality of care and to investigate whether other evidence might also confirm higher than expected deaths in a hospital such as morbidity data. The analogy we most often use around HSMRs is to compare them

to a smoke alarm, so that in and of themselves they don't necessarily mean anything sinister, but there is certainly a cue to go digging and investigating.

The Australian Commission on Safety and Quality on Health Care has developed and sanctioned two HSMR models that are used across the Australian Health System. The Core Hospital-based Outcome Indicator, or CHBOI HSMR, has been in use since 2009 while a new Australian composite model, ACMHSMR was introduced in 2015. The Australian Commission does not publish national HSMR results directly, but periodically makes available statistical models and national risk adjustment coefficients to allow jurisdictions to calculate local HSMR values relative to national rates, and that is what we do.

Without wanting to get lost in acronyms, the two different HSMR models -

Mr VALENTINE - It is the world of acronyms in Health, isn't it? I thought ICT was bad until I joined Health.

Mr PERVAN - It sure is. I will give you a great one at the break, but the two models each generate results for the Tasmanian hospitals. However, neither model indicates any statistically significant change in the two different HSMR values in Tasmania's four main public hospitals in recent periods. So by recent periods, we mean going back to 2009.

Quarterly data for both the ACM and CHBOI HSMRs remain within their normal range, so basically it has been quite stable for many years. The Tasmanian Health Service also access a variant HSMR model through its membership of the Health Round Table, which is a non-Government organisation based in Victoria, which has the majority of, especially teaching hospitals in Australia as members. They share data, they share performance information.

Mr VALENTINE - That is good.

Mr PERVAN - It is. It is a great -

Mr VALENTINE - It is like a base, yes.

Mr PERVAN - It is a giant learning set really. The hospital, they have developed their own model, the Hospital Diagnosis Standardised Mortality Ratio, which has the acronym HDXSMR, which is their proprietary measure and isn't used by the Australian Commission or the Health System either at a State or a national level.

Mr VALENTINE - It is not a baseline?

Mr PERVAN - It is just a different model. I am aware that recently the Round Table provided the Royal Hobart in particular with some quarterly data that showed an increase in HSMR or the HDXSMR and that caused concern amongst clinicians and started a conversation between the clinicians and the Executive. I understand that the latest quarterly data is currently being recalculated by the Health Round Table following the identification of a number of data issues, so it looks like, consistent with the national models, there has been no significant change, but what caused the recent concern amongst clinicians was the report from the Health Round Table that showed an increase when in fact that looks like it was a data issue, not one related to risk in the hospital.

Mr VALENTINE - Thank you for that quite fulsome response.

DEPUTY CHAIR - In terms of morbidity, performance information here talks about hand hygiene. It talks about MRSA, but there's a number of other quite nasty iatrogenic infections that are not reported here, so do we have data on some of the morbidity outcomes in our hospitals?

Mr PERVAN - It depends on what you are after.

DEPUTY CHAIR - Yes, VRE, and have MRSA here, but not -

Mr PERVAN - The VRE was withdrawn on a national basis as a reporting measure.

DEPUTY CHAIR - Was it? All right.

Mr PERVAN - On the grounds that the numbers were so small it wasn't statistically significant. The Tasmanian, TICU, Infection Control Unit, collects all sorts of data, and puts it on its website, but as I said, these things are done on a national standard basis.

DEPUTY CHAIR - All right.

Mr PERVAN - Are there any other sources of infection that you are interested in and we will see if that data is available in the system.

DEPUTY CHAIR - I am not sure what they report on now. I would have to check that.

Mr FERGUSON - I am broadly aware of a national surveillance of some of these stats that are provided through AHW and no doubt others in the Commission. We are here to help, note the Committee's interest in that.

DEPUTY CHAIR - I notice the additional funding that was flowing from the Commonwealth regarding elective surgery has come to an end, and your opening comments, minister, first up this morning indicated some significant improvement in that area. Do you have a break-down of waiting numbers and waiting times per category per region that you could provide for us? The most up-to-date figures that you have? Just on a regional break-down, you have got elective surgery patients in on time. We do not have the numbers of patients on waiting lists, but number is a bit irrelevant in many respects. It is the time that they are waiting that is the more important aspect, but I think they are relevant if you look at them in a complete set.

Mr FERGUSON - What I can best usefully provide you here, and it's very tempting for me to now tell the committee how well we are going with elective surgery.

DEPUTY CHAIR - You have already done that so you don't need to do it again.

Mr FERGUSON - I thought you may say that.

DEPUTY CHAIR - Yes, let's cut to the chase with the figures if we can.

Mr FERGUSON - I just want to say, it's an amazing good picture for the State to see so many people getting their surgery.

Mr VALENTINE - That is worth another Jaffa!

Mr FERGUSON - Not reflecting on this Committee but in others that I attend, the interest in this subject has waned, but we are just very pleased that people are getting their health care. The numbers are down, as you correctly identify, but the waiting times, I agree with you, are more important. All right? I do, and I'm glad that you said it because I agree, because the waiting list there is a function of managing a patient demand.

DEPUTY CHAIR - And some people are not ready for surgery even though they are on the list.

Mr FERGUSON - To access the service, so I don't think anybody has a difficulty with the concept of a mechanism by which people wait by category in priority, and I agree with you that waiting time is a far more useful measure, especially if you are one of the people waiting. I can give you some data which reflects by region, in fact not by region but by hospital, what we are looking at here.

There are two that I will give you that I think will usefully answer the issue. One is the number of over boundary patients by region, and the average number of days over boundary that patients have waited. Further information is available on the Health Stats website, by the way. What I am giving you, any number I give you from the following table will be to 31 March, so they are equivalent point in time across date ranges, so the LGH, 2013-14, number of over boundary patients was 1901. At 31 March 16 this year 313 over boundaries. That is, people who have waited longer than recommended in any one of the three categories. For the Mersey it was 64 in that previous time set and it's now 17. For the North West Regional it was 212, it is now 103. For the Royal it was 1114, it is now 761. So for a state, overall the state, the number of over boundary patients at 31 March 2014 was 3291, and at 31 March this year it was down to 1194, which is a much smaller fraction of the total waiting lists.

The other metric which is useful for you and the Committee is the percentage of patients, the average number of days over boundary for patients waiting.

DEPUTY CHAIR - By category have you got these?

Mr FERGUSON - I only have it by hospital.

DEPUTY CHAIR - All right, we will do that.

Mr FERGUSON - If I can look for something else for you I will, but the average number of days over boundary for patients waiting in 2013-14 LGH was 241, and that is down to 68 days, so they are still overdue, but they are overdue only by 68 days, compared to 241. Mersey it was 82. It is down to 54. For the North West Regional it was 137 days, that's down to 66 days, and at the Royal it was 431 over a year. It is down to 88 days.

DEPUTY CHAIR - There is not a Category 3 in this, I suggest?

Mr FERGUSON - Yes, absolutely there is. This is all categories.

DEPUTY CHAIR - Yes, I know, that's why I would be interested to see the actual categories.

Mr FERGUSON - I think we have seen our best improvement in Category 3.

DEPUTY CHAIR - You have, right, yes.

Mr FERGUSON - Secretary? We have seen our best improvement in Category 3.

Mr PERVAN - Yes.

Mr VALENTINE - What is Category 3 for those of us that don't quite -

Mr FERGUSON - Category 3 is the least urgent category, the non-urgent category, so they need their surgery. They do not need it today or tomorrow or next month. They can wait up to a year by clinical recommended timeframes, but traditionally in Tasmania it is the Category 3s who have been waiting for years and years, and, not that you have asked me for it, but at the Royal in 2013-14, the longest waiting patient had been waiting for 3609 days. That is 10 years. That is the longest waiting patient on that waiting list.

Mr VALENTINE - Something like a knee operation?

Mr FERGUSON - It probably wasn't something like that. It was probably something less painful than that, but clinically necessary, and I shouldn't guess what it was because it might even identify someone, but that is the longest waiting patient. No one is saying that that is some sort of average, but that was how long the longest waiting patient waited, and that is now down - at this 31 March it is down to 800 days, so there is still some very small numbers of patients who have been waiting longer than clinically recommended, but the reason that I am reasonably conversant with this is because for the last three years since we implemented our Rebuilding Health Services funding, the $76m for elective surgery, the strategy has been to maintain the existing effort on baseline surgeries that were occurring, but to then use the additional funding to target the longer wait patients, and the Secretary in our first - when he was not a Secretary yet, but when we were first doing - he was doing the purchasing role, we agreed that we would target the longer waits and all children, and actually in that first year I think we actually caught up all those children -

DEPUTY CHAIR - That was last year? The year before?

Mr FERGUSON - In our first year actually.

DEPUTY CHAIR - Year before.

Mr VALENTINE - That is incredible.

Mr FERGUSON - Quite a while ago now. So there has been some remarkable achievements there, and the goal, I hope you would be about to ask me what is next. The goal for us now is, having broken the back on those very, very long waits, and reduce the overdue rate by something like 44 per cent down to approximately 20 per cent of the list, to maintain it at a more sustainable level and maintain on a year-on-year basis the planned activity through service agreements with THS to approximate the number of people coming on as additions to the list.

DEPUTY CHAIR - Thank you, minister, it is a help to look at the improvements that had been made in these areas, but it doesn't take away the fact that there are still people out there waiting who we do need to be conscious of.

Unless anyone has any other questions on 1.1, Admitted Services, we will finish this and perhaps have the lunch break and come back for 1.2, Non-Admitted Services, which we have sort of covered.

Mr FARRELL - I was just wondering, and it is pleasing to see that there was additional funding for John L. Grove which is a great facility. What are the admission numbers like there, because from personal experience, it has always been fairly well occupied, and just wondering if there are any long-term plans to expand that service.

Mr FERGUSON - Thank you, Mr Farrell. If I don't have it at the table, I would like to be allowed to bring it back to the Committee. I think what you may be asking for is occupancy rates, and my advice would - my experience has been that it is very highly utilised because it is a satellite service of the LGH, so it is reasonably able to always use the capability that sits within John L. Grove Rehabilitation Centre because patients who use that service are slow to recover, so actually they are not turning over anywhere near as rapidly or frequently as an acute bed which might be shorter stay, so slow to recover. I think it was approximately, how many days, more than 28, and I think over a month. So that is perhaps the rationale there and I would be happy to give you the precise occupancy rate which would be, I'm guessing right now, it would be very high in the 90s, I'm guessing, and happy to provide that, and also the average length of stay.

Mr FARRELL - Thank you, that would be great.

Mr VALENTINE - Is Wilfred Lopes incorporated into the Admitted Services?

DEPUTY CHAIR - It is forensic, is it? Or not?

Mr PERVAN - It is Admitted, yes.

Mr VALENTINE - What is happening there? I know it has got a smaller feed, if I can put it that way.

Mr FERGUSON - A different pathway.

Mr VALENTINE - Yes, a different pathway. How are they coping with their services that they are called on to provide?

Mr FERGUSON - So the Chief Executive may add to what I say, but I have no concerns raised with me about the model. Its occupancy is, I think, quite low.

DEPUTY CHAIR - Is it?

Mr FERGUSON - Yes, its occupancy is quite low.

DEPUTY CHAIR - That is a change.

Mr FERGUSON - It is not stressed over over-demanded by any stretch, and it provides, as you would be aware, the Forensic Mental Health Service where -

Mr VALENTINE - Perhaps I should ask how are the Mental Health Services, but anyway.

Mr FERGUSON - It belongs where you have asked. I think you are right. It is an Admitted Service.

DEPUTY CHAIR - It is part of the statewide Mental Health Service, is it? Or Forensic Medicine?

Mr FERGUSON - It is part of the statewide Mental Health Service.

DEPUTY CHAIR - Yes.

Mr FERGUSON - It has no pinch points, to use your term, that I am aware of.

Mr VALENTINE - Yes, thank you.

DEPUTY CHAIR - Craig, did you have anything else or are you all right? No other Members on this?

Thank you, minister, and your team, we will come back at 2 p.m. for Non-Admitted Services.

The Committee suspended from 12.58 pm. to 2 p.m.

Output Group 1 - (cont)
Tasmanian Health Service

1.2 Non-admitted services -

CHAIR - I will call the committee to order.

Mr FARRELL - In relation to the increase, the minister talks about the listing of hepatitis C medications. I am keen to get some more detail on that. It is a reasonably good increase of one particular health issue. Are there any other, similar things that we will be facing with going onto the Pharmaceutical Benefits Scheme?

Mr FERGUSON - Chair, when it suits the committee I have some extra answers to provide from earlier today. Thanks, Mr Farrell, this is a question on a subject of great importance to a lot of people in our state. I am advised that in Tasmania about 5000 people are living with chronic hepatitis C and that most of those are likely to be eligible for the new treatments. The new treatments are very substantial and have a very high success rate in terms of cure.

In March, new oral antiviral agents that can cure most people living with chronic hepatitis C infection were subsidised in a great decision by the Commonwealth government. Tasmania has developed new models of care for hepatitis C and we are making early progress towards the long-term goal of eliminating hepatitis C.

The Tasmanian Government supported increased access to hepatitis C treatment by increasing hepatology nurse specialist positions. My department has worked with specialist services and

practitioners to drive new statewide models of hepatitis C treatment, including the increase in general practice-led care.

Most people living with hepatitis C can be managed in general practice but some need specialised care. GPs with experience in hepatitis C treatment can now prescribe these medicines for low-risk patients with chronic hepatitis C. There has been a steady increase in the number of patients benefiting from shared care arrangements with GPs. Needless to say, GPs are at the very grassroots of our communities and have excellent interface with their patients where they live.

The proportion of Tasmanians being treated by a GP, 21 per cent, is higher than the national average of 13 per cent, which is great. It shows that the model has been maturing. Correctional Services also report that it has initiated treatment in 100 individuals. It is estimated that 15 per cent, about 740 of those 5000 Tasmanians with chronic hepatitis C, have started or completed treatment to date, which is quite a high number considering the relatively recent decision of just over one year ago to list that range of new drugs on the PBS. We are part of that, the THS is a delivery partner and our hospital-based pharmacies are part of this. We are very pleased to be participants at such an exciting time for many people who, I am sure, would have thought that this would be a lifelong disease.

I hasten to add that not everybody, not 100 per cent, is likely to be looking at a cure but the advice is that nearly everybody could be cured.

Ms FORREST - With regard to the cancer screening in past budget papers, I am pretty sure we have had it, there has been some statistics on the number of cancer screening services that have been provided; do you have that?

Mr FERGUSON - What would you like, Ms Forrest?

Ms FORREST - Breast screening and cervical screening. I am not sure, I think bowel screening is a commonwealth matter. I do not think we record that, do we, at a state level?

Mr FERGUSON - It is run by the Commonwealth but we are nonetheless involved in it. I will provide you what I can on breast cancer screening, cervical cancer screening and bowel screening. One of the points that might explain your experience with this Budget is that the Government moved what was formerly known as Cancer Screening and Control Services, which was previously in the Department of Health and Human Services separate to the three THOs, into the Tasmanian Health Service.

It is now Population Screening and Cancer Prevention. It manages the joint Australian Government and state Government funded programs including Breast Screening Tasmania, the Tasmanian Cervical Cancer Prevention Program and the National Bowel Cancer Screening Program.

For the population screening programs to be most effective at reducing mortality and morbidity, high rates of participation in the program by the target groups is essential. In the calendar year 2016, Breast Screen Tasmania screened a record number of 31 292 women.

Ms FORREST - That is this -

Mr FERGUSON - In the calendar year 2016.

Ms FORREST - Yes. You said that was an increase; what was the previous year?

Mr FERGUSON - The 2003 calendar year was 28 134 and pleasingly, the figures trend that way in the intervening years.

Ms FORREST - In terms of access, women who have to be referred for further assessment, do you have those figures as well? There was a bit of an issue a while back with this about women not getting timely referrals or when they got referrals, they were not getting access to further investigation.

Mr FERGUSON - You would be aware that for a screening test there is no referral if you are in the eligible age group of 50 to 74. You are asking me now about the follow-up assessment, if there is an anomaly identified?

Ms FORREST - Yes, I understand, unless it has changed. Maybe it has, with the newer buses, but it used to be that if you had a breast cancer diagnosis you could not go back through the bus breast screening program, you had to be screened through the big radiology services.

Mr FERGUSON - I might defer to my officials here but yes the breast screen service is not a therapeutic service, it is a service for the population-wide screening. If there is an anomaly identified, there is a follow-up assessment service.

Ms FORREST - I would call it a referral but follow-up is probably the right word here.

Mr FERGUSON - Afterwards there would be other medical pathways which I might ask the CEO to respond to, if a woman has a cancer.

Dr ALCON - If someone has a cancer the frequency of review is going to depend on the stage of the cancer and the therapies employed. Typically, cancer surveillance of breast cancer can go on for many years - 10 and 15 years. Depending on the sensitivity of the tumour, follow-up is also dictated by the need for any subsequent medication to stop it from recurring. That is quite a different category from the population screening with an anomaly that would then go on to ordinary assessment.

Ms FORREST - The women who are detected in screening as having an anomaly that requiring a follow-up, are they all accessing that follow-up in a timely manner? Do we know that? This was an issue some years ago, that some women were having to wait long periods between the screening and the follow-up.

Mr FERGUSON - My advice is, ideally the national accreditation standard is that 90 per cent of women who require assessment should access that within 28 days. My latest advice is that to 31 March 2017 the rate is 89.9 per cent in Tasmania. There is a bit of room for improvement.

Ms FORREST - A 100 per cent would be good but at least there is a standard there.

Mr FERGUSON - I suppose that is a standard to reach and wondering what then happens with that 10.1 per cent of women who are naturally also being encouraged to have that follow-up assessment. It is not happening within the 28-day window, it may be happening afterwards. We would be always striving for the maximum.

Ms FORREST - It doesn't mean they are not having it, and there may be some women who choose not to, for reasons of their own.

Mr FERGUSON - You did not just ask about breast screening.

Ms FORREST - Yes, cervical screening as well.

Mr FERGUSON - Ms Forrest, you will also be pleased to know, before I leave breast screening, the most recently available data shows that Tasmania's age standardised participation for women in the eligible age group is 56.7 per cent . You would immediately think, there is a lot of room for improvement there; however, it is the second highest in the country. We are second only to South Australia and well above the national average of 53 per cent. Because of its nature, it is a population-wide screening tool, it relies on a woman to book in and choose to make that appointment.

Ms FORREST - On that minister, there are some women who, for reasons of family history or they may have detected a lump themselves, for example, who go through the other clinical process but they still may be in the eligible age group. Were they excluded in that number? It might not be as low as that if those women are taken out, if they are having screening through another process.

DR ALCON - Even if they were having screening through another process, they would be counted if they were a screening case due to family history. We would find the same with other sorts of cancer as well. They would be on a higher frequency of surveillance.

Ms FORREST - I use myself as an example, I do not have a family history but I did find a lump. I went to the GP, who referred me to the service - not the screening service - but now I am on that pathway. I have not been to the screening bus, I do not need to, but I am in the age group so do I count it has one who has not been picked in the age group?

Dr ALCON - You would not be picked up in the screening bus group, no.

Ms FORREST - It might not be as low as it looks; there may be other women like that.

Mr FERGUSON - Cervical cancer: Tasmania's crude biennial participation rate, the most recently published rate, which is for 2013-14, was the third highest in the country after Victoria and South Australia and above the national average crude participation rate. As at 31 May 2016-17, Tasmania's participation rate was 56.5 per cent.

Ms FORREST - Is this just women on the register or is this the screening that is undertaken broadly?

Mr FERGUSON - It is the population-based screening.

Ms FORREST - I understand the schedule is to change from two years to five years for cervical screening. It has not quite come into play yet but it is very soon. I do not know if that will impact the performance information in future years for a little while. I am not sure, it is just an observation.

Mr FERGUSON - The extent of my knowledge on that is the recommended changes by the NHMRC, but we can keep an eye on that.

Ms FORREST - They are checking more for HPV, as much as anything, in those screens now, and for bowel cancer - this affects the blokes, too.

Mr FERGUSON - The screening component of the National Bowel Cancer Screening Program is managed by the Australian Government. The test is sent to all eligible Tasmanians. By 2020 all Tasmanians aged 50-74 will be invited to participate every two years. Raw data shows the participation rate for the program in 2016 in Tasmania was 43.8 per cent of the eligible population compared with 39.5 per cent participation Australia-wide.

Ms FORREST - That is still quite low in many respects. When we had the preventive health committee we were looking at this. It is run by the Commonwealth government and the kits are mailed out to people. It is a costly process because if someone then loses their kit or it does not work on that occasion, they have to have a replacement. We talked about perhaps linking it with other screening services to make it available at more points of entry.

Mr FERGUSON - More places where you could pick up a kit, do you mean?

Ms FORREST - Yes, at pharmacies or even in the breast screening bus. Have the conversations been had with the Commonwealth around that to try to increase the uptake of the screening?

Mr PERVAN - No. There is still a very robust discussion going on both through the NHMRC and other avenues about the reliability of the kits and the FOBT - faecal occult blood test - anyway. There is a very long process involved in getting any changes to commonwealth programs. The avenue to any change to the existing deployment of the kits is not easily identified. Whether the minister can do it, whether it is NHMRC or a commonwealth decision alone -

Ms FORREST - The wheels move very slowly. It is less than 50 per cent of the population and not even 40 per cent of the Australian population, so there are a lot of people out there who could benefit from early detection.

Mr ARMSTRONG -, I notice there is $900 000 allocated for Digital Ready for Business. Can you explain what that will be used for?

Mr FERGUSON - I can, but I would respectfully request that I do that when I have the officials from the Department of State Growth here. They will be on site by no later than 3.30 p.m.

Mr VALENTINE - My question relates to outpatients services and clinics, where you have the person coming in for a particular purpose on a day. Do you have any figures on deferred appointments? Say, someone comes in from New Norfolk on a bus, they have had to arrange to have the day off to go to hospital, they get into the hospital clinic and find that the specialist has been taken away because of an emergency elsewhere so they have to go back home and rearrange another day. Do you have any figures to do with deferral of clinic appointments?

Mr FERGUSON - I do not have that with me, but I will undertake to obtain it.

Mr VALENTINE - I would like to know that because it would measure the amount of inconvenience we are placing on the public. That inconvenience is not small. It could be somebody has driven all the way from Launceston for a specialist service, I do not know.

Mr FERGUSON - I can assist you by letting you know that I have been previously advised that the bigger risk and the bigger inconvenience is in fact patient-initiated cancellations of appointments, or patients who do not arrive.

Mr VALENTINE - I would be interested in that aspect as well if you have both.

Mr FERGUSON - It is actually a source of consistent frustration related to me by clinicians, that they are there on duty, and at times in a regional centre as well, having travelled there. A fraction of their appointments do not arrive.

Mr VALENTINE - I do not what happens with, say, someone from King Island or Flinders Island to have to travel for service at the LGH or the North West Regional Hospital. It would be interesting to know what those figures are for each of the major acute hospitals.

Mr FERGUSON - I will provide that, to the extent that I can obtain it. Secondly, I assure you that one of the steps the THS has been taking has been a more proactive reminder system on the part of the THS for people to please turn up, and if they cannot come, to please take the extra step of calling ahead and allowing that appointment to go to somebody else.

Mr VALENTINE - I realise there are both sides of the coin here. If we can get some idea on both sides, that would be great.

Ms FORREST - I assume your initiative regarding medicinal cannabis, having trialled access for paediatric epilepsy, fits under this area?

Mr FERGUSON - You can ask it here of course. However, if you would ask me during the public health services output, I will have the chief pharmacist here.

Ms FORREST - I will wait until then, that is fine. One other question is, when we are talking about the issues around specialist access, the tele-health we talked about earlier but it fits more into the outpatient setting here, I have communication with specialists from Hobart that provide a service to the north-west. These are specialist services that are not provided in the north-west or not to the extent they need to be. Some of these specialists were flying up from Hobart to Burnie, to Wynyard, which cuts down the travel time enormously, makes them less tired, able to see more patients and they are able work on the way up and back.

That service no longer exists, and now some of those specialists have chosen not to come to the coast and some of them are choosing to drive, which they are finding extremely tiring. Trust me, we know it is a long drive. It significantly reduces the number of patients you can see. It has been put to me that if the Government would subsidise a charter flight, maybe fly several specialists at the same time, to consult on the same day, that this might be a way of increasing efficiencies and overall the cost. They have to be paid for a car anyway so the costs are there. Some of that would be offset by that. Would consideration be given to that to facilitate the visiting specialists to the area?

Mr FERGUSON - I certainly would not say no. It would only be reasonable to consider it if it could be demonstrated that it was actually a better use of resources, including time. We certainly would not say no to it. Operationally, the THS already have the capability to do something like this, an innovation of that kind, if it could be demonstrated it would improve the service provision. I certainly would support that but I would also, in this case, defer to people who are employed to make decisions like that to think it through carefully and decide if it is an appropriate use of resources and if it could maximise valuable clinical time.

Ms FORREST - I think it is something that should be looked at. Whether it stacks up or not at the end of the day, I wanted to put it on the table because it has been something that I have had a number of discussions on with specialists who still want to provide a service to the north-west but it is becoming increasingly difficult.

Mr FERGUSON - That would sit in the same conversation as our earlier chat about tele-health.

Ms FORREST - A fertility specialist actually does need to examine the patient, so you cannot really do that by tele-health.

Mr FERGUSON - I agree with you, it would be a mix of approaches to help people get their appointments.

1.3 Emergency department services -

Mr VALENTINE - We have covered quite a bit of ground in the previous discussions, but it is fair to say that there is a lot of concern out there with how the emergency departments are coping. I know that just at one of the hospitals, the Royal Hobart, there have been up to 100 patients waiting to get through that system, and the ambulance ramping that goes with that, because there isn't the capacity to take those people through into the emergency department. Then being able to place the people in the emergency department into a hospital bed is a cause for concern. Can you outline, especially given that we are in our winter period now, how we are going to cope with possible increases even over what has been happening to date? What measures are you taking to address the critical situation occurring in that hospital? No doubt the LGH and the NWRH are experiencing similar problems, maybe not to the same extent.

Mr FERGUSON - We recognise the increase in patient demand. That is something that is organically occurring[?!] in the community or at least presenting to emergency departments. The numbers are consistently increasing and that is having an impact on the ability of the THS to manage the overall cohort of patients who are arriving, whether it is in through the front door on foot or an ambulance arrival.

There are a mixture of things that I would like to share with you. First of all, and I say this as a non-clinician, the THS's and our emergency department staff's first response and first responsibility, no matter how many are in the area like the ED at one time, is to triage and ensure that patients who require immediate and urgent care are put right to the front of the line. I am sure you already know that this already happens. It is a mainstream element of their practice.

Mr VALENTINE - I've been in there.

Mr FERGUSON - The consequence of course is that if you are not a triage 1 patient, you are likely to be waiting longer than is acceptable or desirable if the ED is very busy.

The Government is responding to this, not relaxed about it, not comfortable or happy with ever seeing patients waiting too long. The first thing that we put in place to address this was last April through Patients First, which I did touch on at our last Estimates one year ago. That set of actions was designed to manage demand better through our emergency departments and essentially improve whole-of-hospital patient flow, especially at the Royal and at the LGH. That is a document with 18 individual actions, one of which is opening additional beds, and a second of which we may talk about later, the ambulance review that has recently been concluded. A third initiative was escalation protocols, which we have discussed. Patients First Second Stage, which has been announced this year and has been fully funded in the recent Budget, commits the funding to add from February onwards for 50 hospital beds around the state. This was announced in February and designed to take further pressure off the EDs and providing better patient access. It is further supported by the Budget which went much further than those first 50.

I have the Chief Executive and the Chief Operating Officer to hand to be able to provide further detail on any other questions you may have, Mr Valentine. Suffice it to say, all of our combined efforts, including with the support of the department, given the magnitude of the task of opening these additional beds, it is a big job. I cannot think of a previous time where a government has funded 106 extra beds. Given the magnitude of that task, it is a joint effort to ensure that we open those beds as rapidly but as safely as possible without cutting corners, noting that at the Royal we have a special challenge. As minister, I want to see the same kind of improvement at the Royal as we were able to experience last year at the LGH when we undertook an additional set of bed openings there.

Mr VALENTINE - I am interested in the system changes you might be making. Are you able elucidate those? The emergency department is to have some minor capital works to the ambulatory area, which will increase our treatment trollies, plaster room, suturing room, et cetera, by three and our chairs by five. The use of ambulatory care to hold ED patients overnight is flawed in many ways, it will simply create another queue for beds whilst blocking a functioning admission avoidance program. These are the sort of comments that are coming to me. Can you explain how those things are being addressed?

Mr FERGUSON - I can and I will very soon as the Chief Operating Officer to talk about some of the initiatives that you asked about at a system-wide point of view.

I think that what your putting forward is as reflection of the different points of view that different people have. I have specifically visited and listened to staff on numerous occasions. If I may go back a step, the Royal Hobart Hospital is of course being redeveloped. The long-term answer to the existing patient demand issues is in fact the redeveloped hospital with the extra capacity of more than 250 extra beds.

Mr VALENTINE - That has been beset along the way by a lot of things that are probably outside the control of any good project manager but nevertheless has to be worked around.

Mr FERGUSON - Indeed and if it had stuck to its original time frames, we would be moving in, or indeed had moved in by now because it was due to be completed last year. That did not happen so the question for all of us is, knowing that the redevelopment is due in mid-2019, how do we work together to best manage the here and now in the intervening years? That is what the additional bed numbers funded in the Budget are about. As I have said, under Patients First, of the 18 actions, only one is opening additional beds. We need to make continued effort across the system

to address that. Even though you have been able to share with the committee some more negative comments about some of the individual measures, I guess it reflects what one person's feels. Others have asked us specifically to make those spaces available.

One of the other things that are happening is the 10 additional acute care beds in the ED area, close to the ED. The Government has funded those but has not explicitly described what model of care will be provided. I am deferring that decision to our management to work through and consult with the necessary staff so that the right model is chosen and it is not the minister dictating that.

We need to be innovative without cutting clinical corners. I will also be very interested to know what the Chief Operating Officer has in mind through the $6 million initiative for a THS-wide operations and command centre, which will provide a systemic improvement to the way we manage our beds and support our staff.

Ms DYMOND - The operations centre will be an exciting new development for us within the service side. Historically, when we have had major incidents or emergency scenarios within health care, we have traditionally established emergency operations centres to pull together our staff, our systems, our information, all into one place so we have that team working together on very much an hourly basis to bring the situation under control.

What has happened in latter years is that a number of health care organisations have now started to move towards running this way on a daily basis. They have established operation centres to help the system become more predictive and more anticipatory in planning for demand on a daily basis.

The concept of the operations centre is a physical thing, it is a physical space within our hospital building which would essentially be a room such as this - not as grand as this one - but with a number of screens of information. It would be a room that would have a number of data screens that tell us what is happening in the emergency department right now, what is our bed status by department and area, how many medical beds we have, how many surgical beds, how many discharges we have today, what our workforce staffing is today, what is happening in theatres today - it will pull together all that information into one place - probably more importantly, the teams of people that are working on managing those systems and those processes so that they are able to talk to each other in the room and work much more proactively to responding to the demand as it is coming in through the door.

The second element of the operations centre is also to get a better understanding of our planned demand going forward. It will also help us understand some of our patterns and become more predictive. In areas such as our outpatients management, managing our elective surgery lists, and planning and rostering of our staff, it will help us to understand, looking forward to tomorrow, next week or next month, what we are likely to be needing to be managing our demand better.

These are proven models that are working well in a number of health care systems. We have been talking quite closely to some similar system and organisations in New Zealand and other parts of Australia as part of our planning to develop our operations centres here.

Staff are very excited and on board about the idea and I think are very eager to have that capacity of that brain, if you like, being developed within the hospital that is one centre of contact that they can go to to understand the big picture in the hospital today and how we respond to it.

An important element of this is that it does run on a set of business rules. We will have clear agreement with our clinicians and our leadership teams in the facilities around things like our escalation planning - what will we do in these situations so that we are ready to go and everything is planned and very structured, rather than responding to escalation in probably a slightly more crisis management way than we do now. It will be a very planned response to it.

Mr VALENTINE - Minister, how much communication has been had with all of the players in that scenario? Is this something that is an ideal and you will get to consult or has it already been consulted with the various medical officers and nursing groups?

Mr FERGUSON - Under the Patients First initiative the set of 18 actions were drawn up by the Secretary to my right and the Chief Executive Officer to my left last year at around the Easter period when we did experience some quite unacceptable individual incidents where patients were waiting far too long. I called for that report, the Government considered it and supported it and in the subsequent Budget we funded it.

The way that it has worked since then is, they are broad goals and broad actions but then they needed some implementation. It is during the implementation of those various planned actions that we have seen the THS and the department doing that rich engagement with staff.

I know and I am well aware of the different points of view about the quality of that consultation but I certainly stand by it and I always want to see if we can enrich and improve it because it is by working together that we get the very best results.

Mr VALENTINE - When will that be fully functional in the Royal? Is it now?

Mr FERGUSON - The command centre or something broader?

Mr VALENTINE - No, what was being described.

Ms DYMOND - We have appointed a project director who is working right now to pull together teams in each of the facilities so we have a local team in each area. They have been working on a new revised escalation strategy for the winter period.

Mr VALENTINE - For this, what we are in now?

Ms DYMOND - For this winter period. We are anticipating, because we are working on the capital construct of these areas within the facilities, that we will have an identified location and our 'baby op centres' by the end of July. They will not be fully functioning in the way we aim and hope they will be, but they will be in place to make an impact over winter. They will be working on the new and revised escalation strategies as they are coming out.

Mr VALENTINE - What about the other areas? What about the LGH and the North West, if there is a problem there too? Is that same thing going to happen in those areas and how are they progressing?

Mr FERGUSON - I would say they are progressing very well because we have seen exactly what I have been saying we need to have. We have seen that happen at the LGH. The North West Regional has been less of a challenge but it does have its periods when it experiences patient surge,

increased numbers, and that is why the additional beds there are specifically designed to support greater numbers of beds for patients to be cared for.

I want to go back a point; you asked whether consultation has occurred. It has, and the Government, when we announced the 27 beds for the south in February, and acknowledging always that it takes time to do that, it has now occurred and the 27 that we settled on was a composite, a make-up, an aggregate, of a range of spaces that were all supported by the relevant stakeholders that you may be thinking of. We specifically took the trouble to not just work up the possibilities and proposals but then to consult about then. That occurred. There were even some proposals for additional bed spaces, including one which was on site, which was not supported and so in the end the Government did not attempt to proceed with that proposal. It points to the consultation that both management has engaged in and I, as minister, have even done some consultation on. On the next stage, which is more recent news, that the Government is funding 10 beds in the ED area, I was personally asked to do this by key leaders at the Royal Hobart Hospital. The Government has delivered that. I have chosen to be careful to not prescribe a model of care; that is not really my job, it is not something I am good at but the THS management is. In designing that, it is also consulting our staff. The Repatriation Hospital is a whole other project that will take quite some time to do but the intention is to have that in place for next year, noting it is quite a large project. The Government is fully funding it at $7 million, even though in just two-and-a-bit years we intend to be taking delivery of the new buildings.

Mr VALENTINE - Have the staff associations been across this, are they accepting of it? I am being told that it simply might create queues and multiple bed moves, which means you have to have cleans, which creates work when you are moving beds around.

Mr FERGUSON - I am going to say this very respectfully, they asked for it.

Mr VALENTINE - They asked for it?

Mr FERGUSON - The nominated spokesperson for that organisation has asked for that and we are doing it.

Mr VALENTINE - There is only one last question and to do with the fact that we get people through the emergency department doors, different types of people at all times of night -

Ms FORREST - It is universal access.

Mr VALENTINE - It is universal access but they can be in all sorts of states. They may well be only needing GP services. I know there is a bit of an education campaign going on there. Isn't there a way of being able to peel those off a lot earlier, rather than having them wait, to have an extra triage service that reduces the number that are presenting for considerably worse problems that need attention in a hospital?

Dr ALCORN - The secretary or I could answer this based on what Dr Tony Lawler and most emergency physicians would say, that this cohort you are describing of GP-ready patients who are presenting to EDs, is something of an urban myth. There have been published studies that have revealed that the proportion that most people would concede is not accurate.

Mr VALENTINE - You are telling me that the 50 or even 100 that are waiting for service through the emergency department are all people that definitely need hospital service?

Dr ALCORN - Yes, I am. I do not know if you want to elaborate, Secretary, but that is certainly my understanding.

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Mr PERVAN - I would agree with the CEO. There have been multiple studies across Australia and around the world about the people that are attending EDs.

There have been assumptions in the past that, of the five Australian triage-scale categories, the 4s and 5s, the lower ones, could go and see a GP. That has been further investigated and found not to be the case.

Mr VALENTINE - It is not the case here? And across the state?

Mr PERVAN - Across the state. There is a higher proportion of lower acuity attendances at the Mersey than there are at the Royal, for instance. The attendances were almost mirror reflections of each other.

Notwithstanding that, it is not just seeing a doctor or a GP in the case of people going that pathway that an emergency department does, there are also other services there that people may need. They do not necessarily need admission but certainly treatment before they can be returned home. GPs are only able to do limited treatment in their rooms.

Ms FORREST - And assessment, too.

Mr PERVAN - Indeed, and assessment.

Mr VALENTINE - How is our hospital performing with the number of people coming through the door of the emergency department for treatment? How is that looking on an average, national scale?

Mr PERVAN - One of the complexities about answering your question is that we have recently been having some very interesting discussions with directors of medical services, clinicians and administrators in other states. It is very hard to compare Tassie to elsewhere, especially in other cities. You can go in an ambulance bypass and we can't. Basically, there is nowhere else for these patients to go. The private EDs offer very limited support, for want of a better word, so we have to deal with everything that comes through the door.

Against the national benchmarks that were set in the National Health Reform Agreement, we are not performing as well as we could. There certainly has been some improvement in Launceston but once again, the context of Tasmanian emergency departments is slightly different. When the pressure is there, we have to deal with all of it.

In those circumstances and with the growth that we have seen, we have seen some outstanding performance, in its context.

Ms FORREST - I want to talk about security of staff and patients in the Department of Emergency Medicine. We have heard stories of the ambulance bringing in patients that are less than cooperative. With our rising ice problem around Tasmania, it is probably adding to the problem.

One of the concerns that has been raised is that security guards, if they are in place, and many of the hospitals do not have them on 24 hours a day, cannot actually physically assist with the patient's management, restrain them or anything like that. That requires a police presence. Is this an area that needs a bit more attention, minister?

Mr FERGUSON - We would always make sure that we are giving constant attention to this. The CEO will expand on this. Staff safety is very high on my priority list. It requires a multi-pronged approach. I feel the opportunity is there for legislative support. On a practical day-to-day basis, on site, if there is a risk identified, we need to manage that risk.

Ms FORREST - Prevention is always better than cure in these things.

Dr ALCORN - If our duty of care requires that we restrain someone for their own welfare, of course our security guards would assist to discharge our duty of care to the patient. The duty of care to staff, we cover off on. Sometimes the presence of security guards, without laying any hands on, but for a large number of people, will subdue people. We also have a de-escalation room in the emergency department that someone who is intoxicated with a substance -

Ms FORREST - That is in the Royal Hobart Hospital DEM but we do not have those in the other DEMs?

Dr ALCORN - Yes. Sorry, I thought your question about the Royal Hobart Hospital.

Ms FORREST - No, it is all of them. It happens everywhere.

Dr ALCORN - That would be the approach throughout the THS. For someone presenting to a hospital where there is not a security staff presence, a small rural hospital, that would have to be dealt with on its merits and involve local police if required.

Ms FORREST - How are staff in the DEMs equipped to manage this?

Dr ALCORN - I spoke earlier about the role of training staff in aggression behaviour management and the rollout that has taken place in that. Having the right staff mix means having experienced nursing and medical staff as well as graduates. Giving that level of containment around what is a well-recognised problem of ice, ensuring we have very good video facilities that will enable us to bring security guards to one spot if there is a Code Black called and also, if we need to police evidence, if someone has assaulted a staff member, then that is available for them. It is a mixture of prevention, dealing with that if and when that presents itself as a problem and making sure, if it occurs, that there is suitable redress for the staff who have been injured.

CHAIR - As an aside, minister, I had a personal experience early last night where I had to be admitted to the emergency department at the Royal Hobart Hospital. They were very busy and I am full of admiration for the professionalism, the care and efficiency with which they went about their job. I did, by chance, mention we had Estimates today and you were here and they said, 'Could you please put in a good word for us'. So here you are, I have.

Laughter.

Mr FERGUSON - If I had known you were going to be admitted, I would have asked to put in a good word for our staff. You have already done that. Thank you for that and thank you for the feedback, which the CEO will pass on.

CHAIR - It was just a personal observation.

Mr FERGUSON - We will pass that on, as we always do, and it is consistent with what the public are saying.

CHAIR - You have some answers you want to put through? If you could table those, thank you.

Mr FERGUSON - It might be more convenient to the committee if I table the further response to Mr Valentine's question on IT in Health.

Mr Gaffney asked me earlier for some more detail on the regional allocation of the mental health packages. MIcare is a flexible program and works to provide services across the state consistent with individual needs. The advice is that 65 per cent of packages are provided in the south, 20 per cent in the north-west and 15 per cent in the north. The key focus of the care packages is direct care coordination and support for the person consistent with their individual needs, which is a response to your question about kind of person would provide the care. The advice I have is, while that might be the pattern of packages, that can change depending on where the next need might be. That was in relation to MIcare, for adults.

In the iConnect program which deals with children, I am advised there are currently up to 16 packages provided, around five in each region.

I also have some forecast data on locums, which is broken down by region. Ms Forrest asked me to make up the total to the $27.75 million. In the south, $1.517 million -

Ms FORREST - What is the measure here, minister?

Mr FERGUSON - Dollars, forecast to the end of the financial year. North, $9.383 million, north-west, $16.851 million.

Mr Farrell asked me about the John L. Grove Rehabilitation Centre. The occupancy is near 100 per cent. It is 97.8 per cent, and the average length of stay is 34.6 days.

Ms Forrest asked me about the number of nurses by region. I have those figures up to 31 March. In the north-west, it is 609.43 FTEs; north, 1172.57 FTEs; and south, 1728.47 FTEs.

CHAIR - Thank you, Minister.

1.4 Community and aged care services -

CHAIR - Minister, on 1.4, I note, that work is underway to reform the Community Nursing Service. Could you advise what has prompted the review of that very important service, and do you anticipate any significant on-ground changes or major budget indications?

Dr ALCORN - For the existing packages, the federal sphere has changed and the Secretary can speak to that. The state sphere is continuing to support aged care and other persons with community needs. We have had a very long and good history of community nursing services throughout Tasmania. They provide a variety of services, not only to aged people but also disabled people, palliative care, et cetera.

It has come to our attention that we need to be very much focused in the primary care setting, in particular in relation to our primary care practitioners. After all, they shoulder the major burden of dealing with managing chronic illness.

We have had several very good initiatives around our community nurses and I would like to showcase one before we go on to talk about some structural changes that we consulted on that we are initiating. The example I want to give you is the common [? 2.58.55] service, which is essentially community nurses who work with general practitioners in the Launceston area to avoid hospitalisation. This is a terrific program, where we have been able to prevent our EDs being filled with people who would otherwise require not only occasional admission but frequent admission. A classic example is a young man I spoke to who had cystic fibrosis, which is a disease that fills the lungs with mucus and requires a lot of hospitalisations.

Through referral from his GP to this community nursing service, he could be managed. He could be managed in his home and he could go to work. He was able to continue his life whilst his GP, who knew him well, continued to prescribe his care and liaise with hospital doctors but, importantly, without needing to be in hospital. You can imagine what that means for a young man who otherwise would be facing repeated chronic hospitalisations.

That is in the process of being evaluated but we fully expect that we will be able to roll that model out in other centres.

I will pass now to Ms Dymond now to talk about our wider work with community nurses.

Ms DYMOND - Yes, perhaps to mention a little bit about the ongoing strategic development for that area of care.

We have a number of services that sit within primary care in community. The following number of them have been quite separately managed in key focus areas of work. One of the things we are starting to move with now through a process of consultation is working with our staff within community and primary care services about extending their scope, re-looking at their structure as we move forward with the statewide concept. It is something we gave to them as an option as opposed to continuing to be linked into the various hospital programs.

We gave them the option of taking a white piece of paper and thinking about how they can structure themselves statewide to review what their current practice is, and where they are identifying some of the gaps in service they would like to respond to so we can do some good strategic development in thinking about what they are offering, how they are offering it and where perhaps we can help fill some of those gaps and think about future developments and new ways of working.

One of the things we are working on very closely with that group is making sure we have a very integrated and carefully coordinated pathway for patients across our community and our hospital services. How do we make that transition of care very smooth for patients so they feel it

as a full journey rather than out there and in here? The primary care and community services have responded to that really well. They are part of an ongoing project of support at the moment. They are working on developing that. They will be putting together for us what will be a three-year strategic plan for refocussing their activities completely, re-looking at their structure and how they position themselves statewide. I think that will be a very productive piece of work and hopefully one that will see us get much better coordination and integration for patients who are using services, both in the community and in the hospital setting.

Mr FERGUSON - I thought you would like to know as well one thing that is different this Budget compared to previously. The Child Health and Parenting Service has been adopted into the THS from the department. It is where it was originally, as it happens. This Government has reversed a decision by the previous government to do that. For whatever reasons there may have been for the move into the department or to separate it from the other parts of the THOs that were delivering health service, we have brought it back in from 1 January this year. This is to allow a stronger program of support for our child health nurses and parenting nurses to engage in richer PD[paediatric ?], to form linkages with other key THS services for parents and children, and to also improve the career pathways for child, maternal and family health. I am further advised the decision the Government took to do this would support greater ability to recruit and retain key staff.

CHAIR - I have a general question. Minister, unfortunately as we know much of our rural and regional populations have lesser outcomes than desirable compared to the national average Therefore, rural hospitals come under this output and that makes them very important. Are you satisfied with the resourcing we have, within our budgetary constraints of course, and the general performance of our rural hospitals, and are there any changes in the wind?

Mr FERGUSON - Chair, I am happy to report that my and the Government's position on the status and the role of our rural facilities has not changed since we released the white paper in June 2015 which painted a very stable and positive future for our primary health sites, including our rural inpatient facilities. If anything, they have a higher role in my own mind and in our service's mind because they are part of the answer for some of the pressures our larger city hospitals are experiencing. With an average occupancy of approximately 50 per cent, there is scope - where appropriate and where safe, for a subacute patient, provided they are willing and there is medical cover at the rural site - for that patient flow to be improved and even more beneficially utilise our rural sites.

CHAIR - Did you say an average occupancy of 50 per cent across all our rural sites?

Mr FERGUSON - That is right.

CHAIR - I am surprised, I thought it would have been greater than that.

Mr FERGUSON - They are being used. That reflects that there is underutilised capacity. That does not mean they are necessarily staffed or funded for all those other beds but it means that -

CHAIR - They can be utilised more fully.

Mr FERGUSON - Precisely, and that is exactly what we are doing at New Norfolk.

Ms FORREST - On that, are you able to provide a breakdown of the occupancy of each of the hospitals?

Mr FERGUSON - We published that before and I could find that document for you again. We had a major report into it about 18 months ago.

Ms FORREST - Yes, but I am talking about this last year, the current figures for the occupancy rates.

Mr FERGUSON - I will see what I can do.

Ms FORREST - One thing that used to be recorded in the budget papers was the breastfeeding rates now CHAPS is in this output group. Do you have those at six weeks and six months?

Mr FERGUSON - We will undertake to obtain what we can for you on that. With the follow-up checks it would be an obvious place to be identified.

Ms FORREST - I am quite sure the data is recorded as part of the data recording.

Mr FERGUSON - You are asking many questions on very fine detail, which you are entitled to do, and I will seek to do my best to obtain the data for you. I do not always know if that level of data is available to me but I suspect in this one it is and I will seek to get it.

Ms FORREST - It is a key indicator at the family and child health centres. We know the benefits of breastfeeding for a baby.

Mr FERGUSON - No argument. When I say I will take it on notice, I want to let you know I am not always able to guarantee I will have it in exactly the way it has been asked, but I will do best effort.

Ms FORREST - With the Oral Health Services, the occasions of service general and episodic, the target was to drop below what was delivered last year for adults and children. Is it tracking to be better than target? Dental health is very important for a range of reasons. I notice the denture waiting list is reducing so maybe people are having their teeth taken out, which is a bad thing if that is the result.

Mr FERGUSON - My advice is that the adult general waiting list as at 31 March 2014 was 15 333. As at 31 March this year, it is 8127.

Ms FORREST - That does not sound right, minister, because the actual last year was 7162 on the adult waiting list.

Mr FERGUSON - Most likely I have given the March date to give comparison with the earliest year that I have available here. If those actuals would have been of 30 June, it might explain some deviation.

Ms FORREST - You said there was 15 000 in the year to date, last year.

Mr FERGUSON - No, I did not say that and if I did, I apologise. It was 2014, which is prior to the performance information in the Budget, page 112. My information is that more or less when we came to office in 2014 as at 31 March, the waiting list for adults was 15 333. As at March of this year, my information is that the waiting list is 8127.

Ms FORREST - So it is still increasing.

Mr FERGUSON - My information is that the waiting list has nearly halved.

Ms FORREST - From last year, I am comparing it. In the performance information in that table there, it says that the actual for 2015-16 was 7162. You are saying it is now likely to be over 8000.

Mr FERGUSON - That was as at March.

Ms FORREST - It is only going to get more.

Mr FERGUSON - I do not have the forecast figure for the full financial year.

Ms FORREST - Even without the forecast figure, minister, it is still higher.

Mr FERGUSON - I am not arguing about that, I am saying that is the latest number of the waiting list we have. I was partly responding to the assertion that the waiting list is going up and it has halved. No doubt we can always do better. The chief executive is advising me that there has been a delay to recruitment of some dentists, which arose out of the delays of the National Partnership Agreement. The chief executive is advising me that there will be a catch up of that as well.

Ms FORREST - Which possibly also accounts for the reduction in the episodic and general care, is that right? Do we have the figures for the last year to date in March and the current year to date in March?

Mr FERGUSON - The chief executive is saying to me that he believes it does account for that. The 2016-17 target is 19 765.

Ms FORREST - That is for dentures.

Mr FERGUSON - I beg your pardon.

Ms FORREST - Both general and episodic care appear to drop back.

Mr FERGUSON - Sorry, I should have said 31 767 and as at 31 March we had performed 23 745 occasions of service and I will ask the chief financial officer to say on record what he just said to me.

Mr WATSON - In doing the comparison between actual and target and drawing a 'this is a drop', the target is set at a baseline level that is a minimum standard performance that is reasonable for the amount of resources -

Ms FORREST - That is how I phrased my question at the start, though. I said I know it is a target and I asked how it is tracking with that. Even from the actuals from 2014-15 to 2015-16, the general occasions of care for adults dropped back. Are they continuing to drop back? The target would suggest yes.

Mr FERGUSON - Last year, there were 32 402 occasions of service; in the full financial year to 31 March that same year we had essentially done exactly the same number within 100 anyway, of this year's March 31 performance that I have given you. To compare, I would put forward that it looks very much like we are on track to perform a similar number of occasions of service, if not more.

Ms FORREST - Which is still less than what was happening in 2014-15. I am just saying, if that is the case, is there a reason for it? I think you have described that in an MPA.

Mr FERGUSON - What I am trying to articulate here is that in March of last year, 2015-16, there were 23 830 compared to this year's 23 745. That nine-month performance looks pretty attractive to achieving a similar number as at 30 June.

Ms FORREST - Yes, I am not disagreeing with you, minister. I am saying it is reducing from 2014-15. I would be concerned if it kept falling back and we know the importance of dental hygiene and dental care, episodic and general. You said that there was an MPA that contributed to that. Is there a staff shortage in this area? Are people having more trouble accessing dental care?

Mr FERGUSON - The evidence I have in front of me has full-year performance from the very highest to the lowest over the last three years within a band of about 400, so it is very stable. It is not declining, it is very stable. I am not sure if we are disconnected on how we are approaching this. The advice that I have is consistent with what I have provided to the committee so I am not sure how I can assist more.

Ms FORREST - The question is, are there staff shortages or resourcing issues in this area?

Mr FERGUSON - I am advised that there have been some vacancies and they are now recruited.

Ms FORREST - So all the vacancies have now been filled; is that correct?

Mr FERGUSON - We will check this but that is my advice.

1.5 Statewide and mental health services -

Mr GAFFNEY - There are quite a few people with questions in this line item and I must acknowledge, on the health service system management the budget commitment regarding mental health is already a priority. It is quite interesting there seems to be a correlation between the work that has been going on with Rethink Mental Health and the Mental Health Commission's intensions and how it is reflected in the Budget.

I note that the reduction in funding for this output is attributed to the reallocation of costs across outputs. Would the Minister please clarify where these funds have been directed and what responsibilities will be attached to those fundings? I am looking at page 109, table 25.2.

Mr FERGUSON - Chief Finance Officer, Mr Watson.

Mr WATSON - Minister, I think this reflects simply adjustments to the calculation of outputs. It does not reflect a transfer of funding from the direct Mental Health and Statewide Services to somewhere else. It is not that money has been moved off them, it is things such as overheads and

other items. When you do your output calculation, they have been recast and it is simply reflecting that.

Mr GAFFNEY - In doing that, why would it then go up? Why would you calculate it would go up a similar amount the following year and then up by another couple of million every year after that? It seems interesting that it is - I just do not know how that would be helpful.

Mr FERGUSON - Every year I feel sorry for people in Mr Watson's positions to explain how a line item variation year-by-year actually translates into the real world. Every year there are some of these variances which are often accounting treatments. I understand the frustration.

Mr GAFFNEY - It is not frustration, I just want to understand how it works.

Mr WATSON - The question was about it bouncing back up again in future periods.

Mr GAFFNEY - Yes, it has bounced down by $3 million, then it bounces back up, then you allocate another - that is future projections. I wonder why the tennis effect.

Mr WATSON - As I am advised, it is a recast of the outputs for the current year. Obviously in the future years you have your impacts of indexation and allocations of block funding, so that is just the normal cyclic increase that you see. It is not a return of the adjustment this year.

Mr GAFFNEY - Thank you. On this, I also acknowledge that this output provides for services to clients and families to treat, support and manage mental health disorders in primary health care, mental illness within the criminal justice system, intensive support, alcohol and drug services. Could you comment on the pressures being placed on frontline services, for example, in alcohol and drug services, with fluctuating numbers of people in correctional facilities? How is that fluid when you have a budget to provide services to those groups? I would like just a comment on how that is managed, I suppose.

Dr ALCORN - In terms of correctional health in the prison population, there is a relationship between the size of the prison population and the number of new people coming in and the size of the service. I have spoken with our staff in correctional health. I would venture to suggest to you that the hepatitis C program that you have heard about before is a wonderful example of them being proactive and attentive to the mental health needs of prisoners. More can always be done in prisons. We know there is a high rate of mental health problems and substance problems in prisons but I am satisfied we have a team that is attempting to proactively address the problems.

Mr GAFFNEY - Minister, there are some comments that have come through regarding some adverse outcomes for mental health patients I would like to hear your response to those. There remains a lack of critical number of mental health beds within the hospital system. I am looking at a couple of comments here and I would like your point of view on this. Staff of Royal Hobart Hospital warned there could be more adverse outcomes for mental health patients if the warnings continue to be ignored. The AMA said there is pressure for patients to leave hospital before they are ready because there are not beds for people who are sick, coming in through the emergency departments. Things will go wrong, they have gone wrong, they will go wrong again.

Simon Cooper, the Coroner, said that had sufficient beds been available in the mental health ward at the Royal Hobart Hospital, doubtless he would have been admitted and it is likely he would not have taken his life. It was a real concern at that time. The Department of Emergency Medicine

at the Royal Hobart Hospital is no place for anyone suffering from depression, anxiety, suicide ideation, indeed any mental health issue.

You have Neroli Ellis also saying that it is unsatisfactory. You have Dr McArthur from the Tasmanian branch of the Royal Australian and New Zealand College of Psychiatrists saying they have written to and had interviews with influential people who are involved in these decisions. Unfortunately, the advice of the College has not been heeded. The AMA said clinical staff around mental health believe very strongly we need to inject funding into the acute sector at the Royal Hobart Hospital. We need the 10 beds back that have been cut by the Government.

I will give you the opportunity to comment and give some rationale or some words about where that issue sits at the moment.

Mr FERGUSON - Thank you, Mr Gaffney. I will begin by selecting out the reference to Coroner Cooper's findings because that is a very weighty issue on my mind, on all of our minds. Collectively, none of us want to see any suicides that are preventable. I respectfully make the point that we would never ever ignore any coroner's reports, they are individually assessed and taken into account by THS at the highest level, indeed at governing council. There is a constant and unrelenting focus on quality and safety and identifying shortcomings which are highlighted from time to time. You have not, but others have, suggested such reports are overlooked or ignored and that is absolutely not the case. Coroners' reports are there for a reason, for us to learn from them.

Broadly speaking, there are a lot of things being said about mental health and the provision of public inpatient services. I have some points to make about this. The current mental health service system in Tasmania relies heavily on public mental health services and in particular inpatient services. There continues to be high demand for these services, which can at times make immediate access difficult.

Community support is an important part of the contemporary mental health care. Greater access to community support is the key to reducing the level of demand on these services and to positively influencing the recovery of people with mental illness. That is what the literature review that underpins the Rethink Mental Health plan told us. That is exactly what consumers and their stakeholder representative organisations told us when we were developing that plan. It was not an insular plan, it was not just a creature of government, it was genuinely a whole-of-community process to engage.

Shifting the focus from hospital-based care, which you and I exchanged on earlier today, to supporting the community is a key focus of Rethink Mental Health. That does not mean to abandon or disenfranchise the need for inpatient mental health services but it does mean that this Government and the previous government, to its credit, understood and attempted to develop more models of support in the community. That does not mean it is as good as it gets. What we have right now - if you do not mind, I might focus for a moment on the Royal Hobart Hospital -

Mr GAFFNEY - That is fine.

Mr FERGUSON - as that is where we are experiencing the increase in demand. We have a brand new building there, a 54-bed, $23 million facility which was not part of the original Royal Hobart Hospital redevelopment plan. The 'original plan' was for those mentally unwell people to go somewhere else in Hobart.

Far from ignoring advice, the advice I took from our senior clinicians, who were very worried about that, was that we need to find a way to keep these patients at the hospital where the other services are - the Emergency Department, the ICU and the Cardiac. It is for that reason we felt the need to pause the project and take count of what we had. One of the key findings was to build this new structure even though it is temporary and it is there for the life of the project, the future of course is the new K block.

Noting we have done all of this work and noting the new building, even though it is temporary, is vastly superior to the B block building that staff were working in, which is now demolished, noting all of that and mindful of the increase in demand, I have asked the department and the THS to identify what we can do to support people presenting at the Emergency Department at the Royal in larger numbers. We also need to continue our work under the Rethink plan to increase community support and reduce the reliance on acute hospital-based mental health services.

As I did say to another Estimates committee earlier this week, this is not as good as it gets. If we can do better, we want to and we will. It requires us to come together as people of good will to find solutions to those increasing pressures. Our mentally unwell patients are as deserving of timely and safe access to care as any other patients.

Mr GAFFNEY - I will stay with mental health but we will go away from the Royal Hobart, although I want to come back to there about another issue.

If we go to a regional focus on the north-west coast, we regularly hear about the Spencer Clinic that it is sometimes full. The trouble is not, I am led to believe, the beds needed but it is the lack of subacute accommodation that is available in the area to look after somebody going from there. It has been raised on a number of occasions that they do not need that bed but they need to be assisted somewhere else.

Ms FORREST - Step-down.

Mr GAFFNEY - Yes.

Mr FERGUSON - That is exactly what we have been talking about; is your question, what access is there for that sort of service in the north-west?

Mr GAFFNEY - Yes, and what is in the future to address that need? It has been there for a few years.

Mr FERGUSON - Mr Gaffney, I was asked a similar question at the other Estimates committee. I have asked for that information to be compiled and it is just as easy for me to provide it to this committee when it is ready. It is not ready but when it is ready, I would love to do that.

Mr GAFFNEY - Yes, that would be great.

Mr FERGUSON - The intention is to give the other committee, and therefore this one, the opportunity to know what is the level of provision for inpatient, what is the level of provision in community mental health and what is the provision for supported accommodation.

Mr GAFFNEY - Thank you. Back to the Royal, what is the current intention for the number of available beds in the psychiatric unit at the Royal, and the number of beds available to the south?

I think last year I asked how many full-time PENs there were and I think there were just under five. They were all based at the Royal. Could you give me the intention of the number of available beds and the staff?

Mr FERGUSON - I will ask the CEO to answer the last part of your question first and I will come back to the beds.

Dr ALCORN - There has been a core group of about five or six PENs, however we are looking at the position and readvertising the position at a slightly higher level so we may well get more people applying. Because of the volume issues that you have spoken about, where we have a suitably qualified applicant, we would be minded to appoint them permanently in any case because we will be able to use them in our system.

Mr GAFFNEY - When you say that, do you mean if you had suitably qualified PENs there would be six or seven positions? Do you want to increase the number of FTEs in that area and will they always stay at the Royal?

Dr ALCORN - Staff mobility is something that we consult with our staff about. They may move around in the Royal in the sense that they might want to spend some time on the inpatient unit and other parts of the emergency department but we have, at times of surge capacity, very good staff who have been willing to move between hospitals and do a week of shifts in the other hospital. We have staff willing and able to do that, we would accept it, but we have no pre-organised plan for them to move around automatically.

Mr GAFFNEY - For all those of us who are not overly familiar with the qualifications of a psychiatric emergency care nurse or a nurse, is that extra study and training, or is it just experience? How does that work?

Dr ALCORN - It depends a little bit on the generation of the nurse. Originally, it was possible to train in psychiatric nursing without acquiring general nursing skills. For example, Dr Len Lambeth, who is our Director of Psychiatry at the Royal Hobart and started out life as a registered psychiatric nurse. Now he is the chief psychiatrist there.

That mechanism has gone by the wayside. It is now a university education and as people move towards, for example, a nurse practitioner level, which would be above what we are talking about with the PEN, they will often enrol in a masters level degree and a period of study.

Mr GAFFNEY - Back to the beds, minister, if you have an answer there.

Mr FERGUSON - Yes, I do. The provision at the Royal right now is for a total capacity of 33 beds. That is the maximum physical capacity. For the reasons that I have outlined earlier, I have asked the THS and the department to work together on any other innovations that might be able to provide better bed access for people who require it.

The CEO has just reminded me that the Budget does provide for additional spaces at Tolosa Street and at Roy Fagan. The Roy Fagan beds are now in place, the additional 10 beds were opened on Monday. They are not synonymous with J block beds but, nonetheless, they are a resource that might potentially be useful for some patients.

I am not blithe to the issue; it is something like the non-mental health patients experiencing this increase in patient demand, which is not something government can control. What we can respond to is the way our service adapts and does to ensure that we are being flexible to what the community needs of us.

Mr GAFFNEY - The next one is a bit to do with the commission's intentions report. It might be an opportunity for the minister to address, with this report in your Rethink plan, how do you prioritise identifying decision-making regarding future finance needs? I am interested to how that melds together. You have had the input and you have got the work together. That will help target different funding and budget allocations you need to do. What happens now with this report? I want to know how it fits.

Mr FERGUSON - There is a new model coming in that has been supported by the Commonwealth government for a new approach to the way we purchase services. The secretary is quite expert in this so I will ask him to outline it in more detail.

There is also our own process, which is an annual one, of establishing a service agreement between the department on behalf of the taxpayer, purchasing services from the THS as well.

Mr PERVAN - One of the many advantages we have is that we have one THS, we have one department and we have one primary health network.

In the development of our Rethink Mental Health and those purchasing or commissioning intentions from Primary Health Tasmania, there were many of the same clinicians and certainly some of the same staff from the department and Primary Health who were involved in the development of both documents. They were developed in harmony so they do lock in automatically.

We have also had an approach following a discussion the minister had with the CEO of Primary Health Tasmania. We have had a formal approach from Phil Edmondson, the CEO, to undertake co-commissioning. The department and the PHN[?] will be working in close collaboration with the THS around the prioritisation of funds to the areas of the most clinical need and combing funds to get a higher value out of the funds that we have to achieve the same outcomes.

Dr ALCORN - I was going to add, there is really substance on these bones. We met yesterday; we meet regularly. We have a governance group around it and we are using mental health as the archetypal example of co-commissioning. We are specifically interested in using the different funding sources and conditions that go with the funding to close gaps in care that our consumers experience. It is very exciting.

Mr GAFFNEY - In reading it, it was quite thorough and it helped understand the complexities of it. Two more questions. At the last Estimates, I asked about child and adolescent mental health services. At the time, the department had very recently managed to fill eight new positions. Could the minister advise what additional services have been provided to clients due to the increased staff? With the eight more staff, were there more services available or did it just fill in holes where there were no services available in areas?

Mr FERGUSON - This one is very close to our hearts and it has been a longstanding service gap that has been identified and addressed. No doubt we will need to keep an eye on it.

In that budget, the Government provided an additional $600 000 recurrent to increase staffing levels and THS also contributed $200 000 of recurrent funding from within existing resources.

I can advise you that to date, this has led to the following permanent appointments within Child and Adolescent Mental Health Services in the south: a full-time clinical lead, a full-time clinical nurse consultant, a full-time social worker, a full-time administrative assistant, a half-time speech pathologist. Interestingly, the speech pathologist appointment is the first in the state within CAMHS. The clinical nurse consultant appointment is within Perinatal and Infant Mental Health Service and allows what was previously a fixed-term position to be ongoing.

Works to both create new clinical accommodation and improve existing clinical accommodation within CAMHS has also been undertaken and the most part completed. I can also advise you that six vacancies have either advanced selection processes or appointments are pending.

Mr GAFFNEY - Where are they, can you tell me the area?

Mr FERGUSON - This is a brief that I have in relation to the extra support that was given CAMHS south. Did you mean regional or vocational?

Mr GAFFNEY - Regional.

Mr FERGUSON - CAMHS continues to triage all referrals and respond on the basis of assessed risk to ensure ongoing service provision. The remarkable, hardworking people at CAMHS recently advised me that while those recruitments were occurring, they had nonetheless significant backlog of referrals that they were very concerned about. To their great credit, they put in place measures that have seen them significantly address that to the point where, in some cases, they were even able to provide same-day, stop-gap service so at least a service had been provided and some support provided to the family. No doubt there is a lot more yet to do but that was very encouraging.

Mr GAFFNEY - I do not want to dwell on the particular issue other than to find out what happens now, from the ABC *News* report last night about the difficulties faced by patients and parents with accommodating a youth with mental illness. The young person is not to be housed with or be in the same area as adult patients and that is understandable. What are the avenues have been or are being explored to resolve the situation? If you have a problem like this, how do you go to how we can solve this? It is more of that sort of question than the specific instance last night - it raises it but what do you do to address it? What are the mechanisms you put into place to address that situation to make it a more effective solution?

Mr FERGUSON - I am at a disadvantage in answering this because I am not at liberty to discuss an individual case involving a child, even though some or much of the case has been told by others, but not all of it. It is a very sad case and I can only say good things about our staff at the LGH, who were placed in a really difficult position finding themselves providing care to a person with some needs. I want to thank them for working so hard. Admittedly, over a number of weeks, some would say too long, the issue here was that our staff have provided care to a person who came into their care.

My colleague on the other side of the department in Human Services, her people I can also speak well of and have equally been working very hard to identify and upgrade accommodation that is appropriate for the needs of that person. It is a sad case which should never have been the subject of union politicking. Many good people are working, and have worked, hard to provide the

care that is owed to that young person. I understand and I am advised that the long-term arrangements ought to be ready within the next week or so. That is a very good thing.

I do not want to inflame or cause people to wonder what I mean by what I am saying, only to indicate that many good people have worked hard to be caring and just, in the absence of alternatives.

Mr GAFFNEY - I hope I framed the question carefully at the beginning in saying I did not want to dwell on that particular case. At the end of the day, what other options are available for providing inpatient support to youth patients? That is the question I am asking. Although this is a case that has highlighted it, my question was about what other options are available.

Mr FERGUSON - The future is different and better because both in the north and the south the Government has plans to provide youth and child adolescent services and with the infrastructure to support that, which we currently do not have. It is very important and I sense in the question your commitment to it as well. It is needed. It is very overdue and we look forward to seeing that infrastructure delivered.

Ms FORREST - What is the expected time frame for that? It has been identified as a fairly urgent need for some time now.

Mr GAFFNEY - Is that the one in Devonport where they turned the sod?

Mr FERGUSON - What I am talking about there is the Royal Hobart Hospital redevelopment, K block, which has a child and adolescent mental health unit as part of the paediatric model. For the Launceston General Hospital last year's Budget included funds for Ward 4K upgrade and that is due for occupation.

Ms FORREST - Yes.

Mr FERGUSON - I am not sure what I just said, I think I have moved off the Royal.

Ms FORREST - Yes, you are in Launceston now.

Mr FERGUSON - In Launceston the process has just begun for the actual design and it will go to tender this December. That is where that project is at for Ward 4K. Sadly, a little wait but it shows what the future should be.

Mr FARRELL - Referring back to K block in Hobart, that is not complete yet is it?

Mr FERGUSON - No, I should have gone into it more expansively than that. K block is the new building at the Royal, on the large block of land that we now have on Campbell Street, the towers.

Mr FARRELL - When does that open?

Mr FERGUSON - Mid-2019 is the anticipated completion date.

1.6 Forensic medicine services -

Mr ARMSTRONG - Can the minister provide me with some assurance that forensic mental health patients have been well managed and adequately supervised when they are living out in the community?

Mr FERGUSON - I am advised that forensic mental health patients are individuals who have come into contact with the criminal justice system and also have mental health impairment which requires ongoing treatment and supervision. The service also has patients who have not been in contact with the criminal justice system but the particular symptoms of their mental illness places them at a higher risk of being a danger to others. They require more intensive treatment and management than the vast majority of mental health consumers. This group of patients are known as high-risk civil patients. It is important to note that the majority of individuals with a mental illness or impairment pose absolutely no risk to others at all. The Community Forensic Mental Health Service looks after these forensic mental health and high-risk civil mental health patients and is made up of the following: nine community case managers, five psychologists, a consultant psychiatrist, a clinical head psychiatrist, two administrative staff, a service manager, two court liaison officers, and access to occupational therapy services from the Wilfred Lopez Centre.

The current patient client caseload consists of 17 patients at the Wilfred Lopez Centre, where the focus is on establishing therapeutic relationships and providing input and advice into ongoing case management, particularly for when patients are discharged. Community Forensic Mental Health Service currently case manages 74 clients in total; 31 of 74 are forensic clients on supervision orders in the community. A supervision order outlines the treatment that a patient must comply with, and a breach can result in the patient being admitted directly into the Wilfred Lopez Centre. The breakdown of the 74 clients is as follows: the north has three forensic and 16 high-risk civil clients, making a total of 19; the south has 20 forensic and 24 high-risk civil clients; the north-west has 11 forensic patients, most of whom, I am advised, are people with intellectual disabilities; and Ashley Youth Detention Centre in Deloraine has 20 active clients.

When the forensic mental health team consider a decision to apprehend a patient on a supervision order, significant consideration is given to the risk that the patient poses and this is done in consultation with case managers, senior discipline staff, clinical head and service manager in communication with the chief forensic psychiatrist.

The statewide Community Forensic Mental Health Service has service sites in the south, the north and the north-west. The northern and southern Community Forensic Mental Health Service provides the state with a parallel service actively case-managing forensic patients residing in the community on a supervision order and high-risk civil clients referred to the service. The north-west service provides a parallel service for forensic patients residing in the community on supervision orders and a consultation liaison model similar, I am told, to New South Wales for high-risk civil clients referred to the service.

Child and adolescent psychiatric and psychological input is provided to patients who have been released from Ashley. A court liaison service is also provided across the state.

It is a very detailed answer. I hope that is satisfying to the question.

Ms FORREST - On that point, for the 17 patients at Wilfred Lopez Centre at the moment, do you have a breakdown of how many of those are forensic and how many are civil? The reason I ask is that a few years ago a constituent of mine was admitted to Wilfred Lopez after he did become a forensic patient because he had been let down by so many other services. He ended up in Wilfred

Lopez, it was the best place he could have been. It assisted him, he got better and he is now an active member of our community. Unfortunately, he found himself in that facility by failings in the broader system. That is why I am interested in how many are forensic and how many are civil.

Mr FERGUSON - It is a reasonable question. If I can provide you the answer, I certainly will.

Ms FORREST - I am not after names or anything like that. It is just the numbers.

Mr FERGUSON - I suspect it will be fine.

CHAIR - You will take it on notice.

Mr FERGUSON - I have a table to provide to you on occupancy at our Royal sites.

CHAIR - Minister and members of the committee, we might take a short break at this stage and then we will come back.

The committee suspended from 3.54 p.m. to 4.11 p.m.

Output group 3
Statewide services

3.1 Ambulance services -

CHAIR - Minister, would you like to introduce the CEO?

Mr FERGUSON - Mr Neil Kirby is the recently appointed Chief Executive Officer for Ambulance Tasmania. He came to our service late last year and it is his first Estimates committee hearing. He has been doing great work and is off to a terrific start.

Mr ARMSTRONG - The Deputy Chair has already touched on this; there has been a lot of news lately about staffing of ambulances in Tasmania and the number of paramedics. Is there anything you can tell us about the Budget this year where it is going to address those issues?

Mr FERGUSON - The Budget includes $21.5 million over four years to further support Ambulance Tasmania in delivering its vital services. My advice is this funding will support the appointment of an additional 35 paramedics statewide. These additional resources will enable us to fully staff two new 24-hour ambulance crews, one in Launceston and one in the Greater Hobart area. This adds to our previous investments we have made in the north-west coast.

It will also enable Ambulance Tasmania to increase its existing roster coverage in a number of stations so we can improve service coverage to the northern and eastern shore suburbs of Hobart. These extra ambulances will be supported by an additional 24-hour 000 emergency call-taker to ensure appropriate response by these additional crews.

The allocation recognises early findings of the Government's review into ambulance services as we continue to implement changes to meet the current needs of patients in our state. The investment is intended to see improvements in the availability of ambulances, the capacity to better

staff existing rosters, and ultimately our combined goal is a better response and service to Tasmanians who need our emergency support. This sits well in the context of the Government's decision to purchase the services of a second police rescue and aeromedical helicopter.

Mr ARMSTRONG - We have heard a lot about workers in the workplace, especially those who work at the coalface in Health, what campaigns do you have in mind to keep frontline workers safe, including the paramedics?

Mr FERGUSON - We have been very concerned for some time about the incidence of attacks and assaults against our paramedic workforce. It has been happening too much and it is not acceptable. It has never been acceptable but when you start to see that becoming a pattern of life for some people in Tasmania, we need to act.

We saw two quite significant high profile assaults on our staff in 2015. I promised a public awareness campaign to drive home the message that threatening or assaulting one of our ambulance officers is completely unacceptable. We also commenced a one-year review into minimum mandatory sentencing legislation.

At the same time, Ambulance Tasmania negotiated the rights to a campaign which was launched by South Australia in 2015, called 'Keep Your Hands off Our Ambos!'. The campaign was adapted for use in our state and extended to include television advertising. It was launched in October last year in the lead up to the Christmas holiday season. The campaign includes anti-violence messages on the back of ambulances that are in urban communities, posters in pubs and clubs across the state, and we are grateful to the partnership with the Hospitality Association on that, a 30 second advertisement broadcast on free-to-air television, and also a social media campaign.

During the peak festive season, there were no reports of violence or aggression towards paramedics or ambulance officers in southern Tasmania, which I hope indicates the message of the campaign is getting through. The television advertisement, while confronting, was designed to capture people's attention and get Tasmanians to also be confronted, as I was, about this behaviour and to encourage behavioural change. It is a realistic portrayal of what ambulance officers confront far too often. It sends that simple message - 'Keep your hands off our ambos!'.

The Government supports our ambos. We are recruiting more and spending more so that we can increase our capability, and as everybody would be well aware as it has been looked at by both Houses, we did want to bring in mandatory minimum sentences for serious assaults on emergency service workers. Unfortunately, that was not supported. That is where we are at, and we will review where we are and we will always do what we need to support, in practical ways, the safety of our highly valued workforce who, I have to say, step in when the rest of us need not.

Mr ARMSTRONG - Minister, it has been in the media lately about the calls that the ambulance services are getting on things that should not be going to them through the ambulance dispatch centre. Could you give us some examples of those and what you are trying to do to stop that?

Mr FERGUSON - I will ask Mr Kirby to commence the answer and I will talk a little bit more about some of the other actions that we will be looking at through the review.

Mr KIRBY - With 90 000 calls that we get a year, we get a range of calls from the life-threatening and critical ones to the other more interesting calls, you could say, and we documented a few of them recently: calls for sick pets to need for medication when they have forgotten to get their mediations, to itchy eyes, sore ankles and a sore foot that they have had for a few days. They are part and parcel of our work.

What we do have in place in the state communications centre is a dispatch program where our officers triage those calls to ensure that the life-threatening, critical cases get the priority and get the ambulance first. We also start supporting all people that ring, from the time the call is received, so some of those lower-priority calls that we have identified, our professional people within the state communications centre will try to talk them through the issue they have, and in some instances have been able to diffuse the need for an ambulance. We will always respond if we are called for assistance but we are trying to educate the public to use 000 for the purpose of what it is designed for. 'Save 000 for saving lives' is the message we have been trying to give to the public.

Mr ARMSTRONG - Do you have any serial, what would you call them, pests, that continue to ring in?

Mr KIRBY - We have people who regularly contact the ambulance service and one of the recognitions that was in the recommendations for the recently announced ambulance review was in terms of secondary triage programs, where we can engage with other healthcare providers that can reach out to meet the needs of those people in a more specific way rather than the dispatch of an ambulance.

Mr ARMSTRONG - I have heard of instances in the country in particular, where a certain person rings the ambulance and is always 'seriously ill'. When they get there, they find very little or nothing wrong with that person but they still have to attend, which could put the life of somebody who is seriously ill in jeopardy. What happens? Can the ambulance refuse to go to them?

Mr KIRBY - We do not refuse to go. Ultimately, some of those matters can be drawn to the attention of the police for misuse of that service. What we want to do as an ambulance service is recognise what might be the underlying need for that person, if they have a mental health issue that needs addressing. What we are seeing is the symptom of that and we want to respond to their need. The initiative that was recommended in the review released this week gives us the opportunity to explore working with other parties and put in place what is called health care plans for those people so that when they call in, we can immediately react in partnership with other healthcare providers in the community to respond to that person's real need.

Mr ARMSTRONG - You said the police can be brought in to somebody like that?

Mr KIRBY - Only in severe cases. If a person is really abusing the service, it is a matter that is reportable to the police.

Mr FERGUSON - The review identified some of these suboptimal reasons why people might be calling. I do not want to characterise that as being anything like a wholesale issue that is causing significant disruption and I do not think Mr Kirby is either. We are identifying that those small number of calls are disruptive to our capability to respond to true emergency calls, and that is to be minimised as much as possible. When you take that, together with the fact that the data through the review identified approximately 40 per cent of calls did have a health care need but it was not an acute health care need, the proposed approach in the review that the Government will now

consider, is the development of a secondary triage model. This would mean thinking of other ways a person can be directed to or provided with the care they do need, which may not be two paramedics and an ambulance. We will consider that and have a good look at it.

We want to see availability to the approximately 2 per cent of our calls, which are true emergencies - lights and sirens, get there at the earliest possible time. You can only do that if there is a vehicle and a crew available at that moment. That is why our efforts will be geared towards making these investments to better staff the existing roster so we reduce the use of overtime and extra shifts, to put in place the additional crews and to fashion our own service so it can respond in the best-designed way to optimise our response.

Mr ARMSTRONG - You might not be able to answer this and have to take it on notice. With the campaigns with the Heart Foundation and everything, putting it out there that if you do have pains to seek your doctor, have the incidents where the ambulance has been called for heart attacks been declining?

Mr KIRBY - I would not say they are declining. Our workload is increasing at a rate of about 14 per cent per year and I would anticipate the nature of those calls with it. If a person is having chest pains, you want them to call the ambulance. If they are having a cardiac moment, they are the cases we want. We want them calling. If anything, I would hope that work increases because they are the people who need our workload.

Mr ARMSTRONG - I was thinking they have gone to their GP.

Mr KIRBY - They may have but the campaigns have increased awareness. We have the people with the early signs and symptoms of what is a heart attack respond to that in a timely fashion so the proper care can be gained.

Mr FERGUSON - To clarify, the report highlighted that the utilisation of ambulance services is growing at 14 times faster than the Tasmanian population growth over the last seven years.

Ms FORREST - On that particular aspect, minister, as the Chief Executive alluded to, there are often underlying problems for people calling ambulances repeatedly or for what we might deem as more trivial matters. Do you do any work in trying to understand and unpack that so that you can perhaps direct educational programs and resources to preventing the use of ambulance services when they are not really warranted?

Mr FERGUSON - It is already happening and maybe your question prompts us to make sure that we are doing it as much as we possibly can. You might have noticed on the backs of some of the Metro buses we have advertising which reminds people, 'Is it really a 000 case or not?' and think about that.

Mr KIRBY - The call-takers are professional in their role. They have quite sophisticated algorithms to follow. We do call-backs to patients. We do not disregard those trivial calls. We try to support them where they are needed and direct them. We will never not send an ambulance. We do not refuse to send an ambulance but if we are talking to the person, we can lead them to contacting their GP or someone in the community. Our staff are trained to do that.

Ms FORREST - We used to have GP Assist but I can't think of the current phone service.

Mr PERVAN - GP Assist still exists and lives alongside Health Direct, the national health call centre.

Ms FORREST - That is right, Health Direct. Are they likely to be referred to these services or have they often gone to them first and end up calling the ambulance?

Mr FERGUSON - I think we would really need to carefully consider our various options on that. I know that one primary care service has already contacted and made themselves known to us, and we are interested. It is rather pleasing as an early sign of interest because it really would be about ensuring that a person who believes that they are in need of health care is perhaps better informed, including by us, as to what their options might be.

Ms FORREST - I know that pregnant women sometimes, when they think they might be in labour, call an ambulance if they do not have fuel in the car or they do not have a car. They will often call a taxi when there is probably quite a reasonable service - if you are not in active labour and getting close to second stage, you probably can transport by car, most people do - what about those sort of approaches?

Mr KIRBY - The first thing is our paramedics are well trained in childbirth, that is one of their key subjects.

Ms FORREST - No, I am not suggesting - I am just saying do they look at the underlying socioeconomic issue and maybe -

Mr KIRBY - Because of the supportive structures around childbirth, most families are well prepared for that scenario and they know when to call an ambulance in that situation. Most people have their plan organised on what hospital they are going to. It is when things happen very suddenly and unexpectedly and they are caught out that we respond to those types of calls and we provide the services they require at that point in time. There will always be patients who have a concern that they have an emergency, be it childbirth or a chest pain that does not end up being cardiac and thank goodness when it is not cardiac. We encourage people, if they have that concern they should act and we will respond to those situations.

Ms FORREST - Minister, it was pleasing to see - and we did hear this in our briefing recently - that the view of the paramedics that the education program Keep Your Hands Off Our Ambos! has had a positive effect. It seems in the south that something has worked, which is good. I also make the point though that it is important for us to change the message sometimes or alter the advertisement because you tend to switch off a bit after you have seen it a number of times and think, 'I have seen that.' Do you have other strategies and other advertising campaigns in mind?

Mr FERGUSON - I would like to run an advertising campaign that says, 'f you put your hand on our ambos, you might go to jail', and we might go that way but we will give thought to that. What we took advice about was that the South Australian campaign was very successful. It was quite challenging material. We even had a number of people complain about it.

Ms FORREST - Really?

Mr FERGUSON - That is understandable.

Ms FORREST - It is always a good sign that it is working.

Mr FERGUSON - Especially for people who find it very challenging if their children happen to be watching at that time. The message is an important one and the TV medium is just one of a range of media that is used; I mentioned the posters and the social media. It is sad that it was necessary but I think we all agree it was necessary and it had the strong support of the workforce.

Ms FORREST - Do you have other campaigns in mind at the moment?

Mr KIRBY - Our staff did feel very supported by that. A number of staff personally said to me that it was good to have that recognition that they do work in dangerous situations. A number of people in the community have reported anecdotally that they just did not realise that the job of the ambo was so tough in that environment. The message has been effective. Our plan at the moment is to run that message for a while in consultation with the media advisers from the department.

We didn't do it in isolation either, there were other programs that took place in training our staff, information from the police, they have participated in managing that acute situation and trying to de-escalate those situations. It is really part of an overall strategy to improve their protection.

Mr FERGUSON - The police were very helpful to us on that and our key people went out to Rokeby and were trained and then took it back to their stations.

Mr GAFFNEY - Mr Kirby, are you aware of the first response units that operate in Tasmania, like the volunteer ambulance officers?

Mr KIRBY - Yes.

Mr GAFFNEY - How many are there now?

Mr KIRBY - In terms of under the Ambulance Tasmania banner, do you mean?

Mr GAFFNEY - I am sure they are.

Mr KIRBY - We have 55 stations or thereabouts and a good deal of them are staffed either wholly or in partnership with volunteers. Volunteer ambulance officers are a large part of our service and we wouldn't be able to provide the service that we provide without their volunteer support. There are other service providers that provide non-emergency patient transport and some of them provide event coverage as well that you will see out there. We have a working relationship with them as and when required.

Mr GAFFNEY - The first-response unit is at Port Sorell; is Longford still going, do you know? Do they get assistance from Ambulance Tasmania with the training of their staff? You might like to get back to me on that one.

Mr KIRBY - I can get back on the specific stations on where we are at each station. There are about 41 locations across the state where we have volunteers providing services and we continue to try to encourage more volunteers to assist in those areas.

Ms FORREST - Earlier in the day, minister, you said you would talk a bit more about the health transport co-ordination infrastructure with the private ambulance arrangement, would you like to do that now?

Mr FERGUSON - I can because sitting to my left and to my right are the two people instrumental in that. The secretary and the department initiated a refreshing of the private panel for non-emergency patient transport. That is private sector involvement, or at least non-government, some of those are not-for-profit. Mr Kirby, through AT, continues to also provide non-emergency transport service - the non-lights and sirens approach. The secretary could perhaps bring you up to date about how that panel is working, noting that the THS then uses that service and the combined panel. What would you like to know?

Ms FORREST - Are there any costs associated to the patients with this? Can you clarify all that?

Mr PERVAN - The DHHS lead a procurement process to establish a new panel of private providers of non-emergency patient transport, with the new panel being formed in September last year. The panel contract has five providers on it, which has increased from two on the previous panel. The five successful tenderers are able to provide services at a lower cost than the two providers on the previous panel. The two providers who are retained dropped their prices, rather significantly, in the case of some high-quality competition.

At the same time we have been introducing a more comprehensive licensing program under the legislation we have, to ensure that the staff are appropriately trained, the vehicles are appropriately equipped and that the safety of the patient is recognised.

I was wondering if you could clarify the part of your question that went to costs to the patient.

Ms FORREST - Are there any costs to the patient? I assume they are intra-hospital transfers so there would not be a cost but just to clarify.

Mr PERVAN - That is correct. It is a cost that we pick up.

Ms FORREST - Thank you, that is fine.

Mr FARRELL - Just to clarify, how many private providers are there now?

Mr PERVAN - Five.

Mr FARRELL - I take your mind back to when we did -

Mr PERVAN - Ironically, one of them is the Royal Flying Doctor Service which now has no wings and four wheels.

3.2 Public Health Services -

Mr FERGUSON - I introduce Mr Peter Boyles, who is the Chief Pharmacist for the Department of Health and Human Services, and to my left, Tasmania's freshly minted Director, who has just been secured on an ongoing basis as Director of Public Health, Dr Mark Veitch.

CHAIR - We have not had a Director of Public Health for a little while.

Mr FERGUSON - Dr Veitch has been acting and there has been a recruitment process. He has been successfully selected as the ongoing appointment.

CHAIR - Something which was a bit topical a question I have is regarding the infamous Dirty Ashtray Award. There were a couple of statements made, from the AMA particularly and then I will make note of those. That came from Dr Gannon of the AMA, who said -

> Whilst Tasmania has ended smoking exemptions for licensed premises, it is still allowed in outdoor drinking areas. The Tasmanian Government has not provided adequate funding to support tobacco control public education campaigns to the evidence-based level.

Then further, there was another statement made by Dr Kathryn Barnsley -

> We have done an analysis of the government response to the 2017 AMA Dirty Ashtray Award, which gives Tasmania an E rating and relegated it to the worst states along with Northern Territory and Victoria. The Government intends to ignore all the recommendations of the AMA, except it has committed to evidence-based mass media campaigns, for which there appears to be no identifiable funding in the Budget.

I suppose that is one of those matters that hit the airwaves, minister, so I will now give you the opportunity for a response.

Mr FERGUSON - I disagree with some of the things that have been repeated in the question because I am not sure that everybody has always understood entirely what the Government is in fact doing. We certainly want to reduce smoking in the community. It would be fair to say that the strategic plan the Government has agreed upon and has set out as our five-year plan does include the investment in additional social marketing at the levels that the evidence tells us will reduce smoking in Tasmania, as well as undertaking highly targeted quit campaigns. For example, for 2017-18, an additional funding amount of $334 000 will be provided to Cancer Council Tasmania to enable 700 TARPs - targeted audience rating points - to be established. That is the point that at least one of the people in your set of comments was making about getting effective education, I think it was Dr Gannon. We are also helping pregnant women to quit smoking through a multi-strategy approach, including through our THS engagements.

We are undertaking additional enforcement and targeted education, supported by tripling the cost of the tobacco seller licence fee. The bill which is currently before parliament provides for additional quit smoking information where you buy cigarettes and targets smoking uptake by young people by hiring more compliance and education officers. This includes increasing penalties for supplying tobacco products to someone underage to match the highest penalties in the country.

We will control the sale, use and promotion of electronic cigarettes to prevent renormalisation of smoking behaviours and sales to children. We are not banning it, but we are proposing the law should not allow its sale to children and that its sale should be regulated in the same way as cigarettes are.

The bill also mainstreams smoke-free areas regardless of the source of the smoke or the vapour, whether it is a herbal cigarette, a tobacco product or an e-cigarette, to maintain genuine smoke-free areas. This ensures people are free to breath natural air not an unknown evaporated product or an unknown smoke which a person may be able to currently claim is lawful in a smoke-free area even though it is smoke. That will assist venue operators to manage and comply with smoke-free areas. I am aware of a venue operator attempting to enforce a smoke-free area only to be told by a patron that this is not a cigarette. That is the action we are taking.

CHAIR - You are introducing that bill?

Mr FERGUSON - Yes. That clarification of smoke-free areas is also provided for in the bill that is before our parliament.

CHAIR - Mr Dean still has his private member's bill sitting on the notice paper. Without getting into an extrapolated debate on that, is that something you would consider supporting down the track with amendment or anything else?

Mr FERGUSON - The answer is no. We did put out a proposal to consider changing the legal smoking age, or the minimum legal smoking age, but that was not supported, including by one of the organisations you referred to in your first question. These are the measures the Government is taking and want to be supported.

CHAIR - What do you see as being other major public health issues confronting the Tasmanian population?

Mr FERGUSON - The other area we want to pursue is obesity. The Government will unveil more in the near future about that. One way Committee members will be able to participate, because you understand your local communities so well, is to encourage local councils, sporting groups, churches, youth groups, scout groups and neighbourhood houses to think about the role they can play in their community. We will be offering an innovative grant fund to allow local communities to access small grants to enable them to close the gap of their resourcing, so they could run a local campaign. It is not about employing extra people or salaries, but the extra support they might need to run local campaigns where there is a championing of a cause. I would welcome a smoking, alcohol-in-moderation, obesity or more physical activity and losing weight initiative. The local communities will be best placed to run some of those campaigns.

Some of them may not need any money. If some did require some small grants, then they are going to be coming on in the near future. We will be releasing some further information this month. We want people to start thinking about it so when the grants actually do open, they will be able to take advantage of it.

CHAIR - When you talk about small branches, you are talking to $5000-type?

Mr FERGUSON - That is right. For example, a neighbourhood house would be ideally placed to be able to run their local community campaign, maybe using the funding for some small equipment or advertising. We do not want to be prescriptive, but we are looking forward to local championing of the cause.

Ms FORREST - There is a constituent in my area who asked about running yoga, particularly for children and the more disadvantaged members of our community. For her to run a small

business, she has to charge an amount which, even at $10 or $15 the session is beyond some people. Is that the sort of thing she could apply for?

Mr FERGUSON - I do not know. Potentially not. The purpose of these grants would be to allow a local community to run a campaign.

Ms FORREST - Okay, a campaign rather than something like that.

Mr FERGUSON - But also to bring the community together and to achieve something together. It is possible. I would not like to second guess at the moment. It would need to be something that did not come to a point where it is suddenly not sustainable any more.

Ms FORREST - In terms of public health, the minister taking the lead on this. He might actually participate in the Dark MOFO nude swim.

Mr FERGUSON - It is always possible, one year.

CHAIR - Also highly improbable.

Mr FERGUSON - In regard to my earlier answer to Mr Armstrong, I am advised with regard to Ashley Youth Detention Centre, the figure I gave was not for active clients as I said. Rather it would be occasions of service with the Mental Health Services, which would likely relate to a smaller number of individuals and occur over a period of time. To be clear, it is not representative to the number of clients in the centre at any one time. For example, there is a psychiatrist and a psychologist, so one person seeing each of these would count as two occasions of service, and an individual may have multiple appointments, which would account for multiple occasions of service.

Additionally, I can provide the committee with the breast feeding rates as reported at Child Health assessment two weeks, four weeks, eight weeks, six months, 12 months data as at 7 June, provided from the Child Health and Parenting Service.

CHAIR - Thank you. How is immunisation going, for all range of issues for children and also influenza? Are we still seeing some resistance from some people in regard to immunisation, like chickenpox? Just a brief overview.

Dr VEITCH - Generally going well on immunisation, but in some instances, not as well as we would like to, but improving. Vaccinations provided to infants up the age of five are actually doing well. A report released today showed our coverage rates of vaccinations for five year olds was up to nearly 94 per cent as of the middle of last year. Raising the rates beyond that is quite difficult, because you already have a good level of immunity. There are some people who cannot have vaccination and other people who, for practical reasons, vaccinations need to be delayed.

In the infant age group, the Tasmanian community is very supportive of vaccination. The locked on objectors to vaccination are a very small proportion of parents. Only 1per cent to 2 per cent. That has probably diminished, with some of the disincentives for being not vaccinated the federal government has recently introduced. Vaccination of infants is going well.

The area where we could improve is in providing human papillomavirus vaccine for teenagers. For some years we have not been performing as well as most other states with HPV vaccination. What we have seen in the last two or three years is steady incremental increases in our vaccination

coverage of teenagers, both boys and girls. The vaccination coverage as of last year was around 65 per cent for both boys and girls.

Ms Forrest – Sixty-nine?

Dr VEITCH - Around 65 per cent. A number of initiatives over the last few years, working with local government and with families with consent forms, have probably seen the marginal improvement over the last couple of years. We have strategies in mind that will probably improve the coverage of the incompletely vaccinated people, in particular providing some catch-up vaccination sessions throughout the state through high schools for students who have missed out on one of their three doses.

Probably from next year the vaccination schedule will change from two to three doses. That will make it easier to get a complete two dose course. We are also embarking upon some research with two other mainland jurisdictions to explore the reasons for successes and shortfalls in vaccinating teenagers with HPV. We will learn from that how to improve our vaccination rate.

There is some additional state based vaccination programs such as providing hepatitis B vaccine for high risk people and providing whooping cough pertussis vaccines.

CHAIR - I was going to ask about whooping cough for adults.

Dr VEITCH - The state funded focus with whooping cough vaccine is for pregnant mothers in the last trimester of pregnancy.

CHAIR - A couple of years ago, GPs were seeing a rise in whooping cough amongst adults.

Dr VEITCH - You will see whooping cough in adults when it is common in the community. A couple of years ago, maybe a bit longer, we did see quite a bit of whooping cough including amongst adults. Whooping cough is at a very low incidence at the moment. Introducing the idea of routine vaccination of women in pregnancy now, so when whooping cough inevitably increases, will be an established part of clinical care of pregnant women.

Ms FORREST - I welcome the ice and the drugs strategy in the attention to the north-west. One of the initiatives included the new transport options, to improve access for north and north-west clients to the southern specialist in-patient withdrawal unit. I mentioned it in the occupancy of the unit, but are we having challenges in getting the people in who need to be in that unit?

Mr FERGUSON - This question would have been better assistance from me during the THS output group.

Ms FORREST - It is a bit hard to know what fits where.

Mr FERGUSON - It is a THS service. I can still comment on it. If the secretary is able to with his knowledge, we may be able to provide you with what you are looking for.

I commissioned in 2014 in the report you have referred to and it did call for the implementation a client transportation protocol. We are implementing that. It includes funding support for clients travelling from the north or north-west to increase access for inpatient withdrawal management services.

Ms FORREST - I understand what that is. The transport is by funding them or providing a vehicle that transports them.

Mr FERGUSON - The client transport protocol. From the report, the evidence and the advice was people in need of detox were ready to make the decision to do so and had a reality of being somewhat dislocated from where the actual service is located. A timely admission is the key.

In response to the recommendation, a client transport protocol has been developed by the Alcohol and Drug Service working with relevant alcohol and other drugs community sector organisations. This will assist clients and organisations from the north and north-west with transportation to and from the Inpatient Withdrawal Management Unit in the south. The protocol is now operational and so far has been used to assist five clients from the north and the north-west.

Ms FORREST - What is the demand for that unit, with it being based in the south? Is it creating challenges for people getting in, when they make that decision as you identified?

Mr PERVAN - It is not a question of any sort of access block to the unit. There are a couple of clinical necessities before someone is admitted. One is they have to be at the correct point clinically for admission, so it will be effective. Under the model care, they are not admitted until they have already organised all of their post-discharge services; their rehab coming out of the detox unit. Lining up those services in the north-west can sometimes be problematic. They do not admit them until they are ready to detox them and then send them home.

Mr FERGUSON - It is really about sequencing and planning that care and the post-detox care. I am committed to this and the community sector organisations involved are working better together.

Ms FORREST - On the controlled access scheme for medicinal cannabis you suggested this was the right place to ask with the chief pharmacist. I am pleased to see it is being opened up for paediatric epilepsy. When you first made your commitment, minister, you made it clear it was going to be a much broader program. There are many people out there who are very disappointed to hear it is only going to be provided initially for paediatric epilepsy bearing in mind children do grow up. There was a range of other health ailments particularly nausea and vomiting associated with chemotherapy, chronic and unrelievable pain through other measures, and people were led to believe it would be included in the scheme.

Mr FERGUSON - I have several ways to respond. The controlled access scheme is not limited to a particular illness. It has however identified there are three potential areas of involvement for an unregulated cannabis product - and I do emphasise potential. Since it was announced in May last year, the department has now established the expert reference group for a child with epilepsy or cancer and for pain. They are in place and have been done. The most advanced of those is the paediatric epilepsy expert reference group and that is where we have directed funding.

The model is operational from 1 September. The chief pharmacist has been instrumental in this and will speak to it further. The model begins with a visit to the GP, a referral to a specialist who will make the assessments as to whether he or she is even willing to prescribe a product of this kind that is not registered, which is a big call. For that reason the expert reference groups play a key role in authorising that.

I do not know of any oncologists in Tasmania who wish to, or believe that it is beneficial to prescribe cannabis. That doesn't mean there aren't any. Nor does it mean that there isn't any evidence. The Government's priority area is the drug-resistant child with epilepsy. We recognise that they do grow up, but our concern was that opening up the scheme without the workforce to support the extra workload of patients would have been an unfair outcome. That is why our funding is directed at supporting extra clinicians to provide the care to potentially substantial numbers of additional referrals, some of which may result in a prescription of an unregistered product.

I need to be careful in my descriptions here because I do not want to paint a picture of false hope for people. There has been a lot of hope offered by many people who believe it is the answer to any illness. It is not. Clinicians will be guided by evidence because they will be judged by their peers. The Government's approach is not to restrict but to open, but in a controlled way. The Government is mindful of the need to protect patients, who are often very vulnerable, from any form of the practice of medicine that is not strongly and robustly evidence-based.

We will use those funds to employ additional staff in our hospital system to receive the referrals. Even if it does not result in the prescription of a medical cannabis product, the additional paediatric neurology, for example, means that specialist care can be provided to improve the treatment of children, whether or not they are appropriate for a product like this.

Ms FORREST - I commend you on this action. A lot of people believed it was going to be much broader.

CHAIR - Minister, thank you for your people there.

Capital investment program -

Mr ARMSTRONG - Can you give us an update on the Royal Hobart Hospital redevelopment, the Kingston Health Centre and the St Helens Hospital?

Mr FERGUSON - Chair, I introduce back to the table, the Acting Deputy Secretary, Michael Reynolds, and also the Director of the Royal Hobart Hospital Redevelopment, Mr Ben Moloney, who is our expert on the project.

CHAIR - Thank you, minister. Bearing in mind we have a bit to go yet, if we could have a couple of succinct responses to Mr Armstrong's questions.

Mr FERGUSON - I will be brief, and attempt to answer any other questions as well.

I will begin with the Kingston and Glenorchy. Did you mention Glenorchy, Mr Armstrong?

Mr ARMSTRONG - No, but if you can -

Mr FARRELL - I was going to ask about that.

Mr FERGUSON - The Budget confirms $6.7 million to complete the Glenorchy Health Centre and $5.8 million to construct Kingston Health Centre.

Glenorchy is an important piece of infrastructure that has been a long time coming. It has been promised for more than 10 years.

We were advised in 2014, as a new government, that this project was not progressing in the right way. We took a fresh look at it and it is now under construction. The project will be completed in early 2018, providing the Glenorchy community with a modern, multi-disciplinary health facility that incorporates a range of services. It will include a bookable community space for use by the many groups which need a place to meet.

Kingston Health Centre, I suspect, is in your electorate, Mr Armstrong?

Mr ARMSTRONG - No, it is nearby. It services a lot of my people.

Mr FERGUSON - Great. This is a project that has also had a long history, not quite 10 years. We have engaged an architect for the project and will begin construction in the first quarter of 2018. Feel free to pass that onto your community. This significant piece of health infrastructure will be at the centre of the Kingston Park development, giving Kingborough residents better access to allied and primary health services.

Mr ARMSTRONG - It is in the Kingborough shopping precinct, isn't it?

Mr FERGUSON - Kingston Park development. It is anticipated the following services will operate: allied health services including physiotherapy, podiatry, occupational therapy, speech pathology and dietetics, oral health, child health and parenting, drug and alcohol services and community nursing service and mental health services. The facility has been designed so that it can expand in the future, if funding became available.

I am very proud to be part of a government that is getting that project under way so long after it was promised. It replaces the tired Kingston Health Centre, which I visited and no doubt so did you.

The question also asked about an update on the Royal Hobart Hospital. Mr Moloney is able to take more detailed questions. I was asked about how it is progressing. Work is now under way on K block. The project has benefited from a safe-decanting plan, which we discussed earlier today. The plan allows us to safely decant the beds into the newly refurbished spaces, not just in the new J block building. There are spaces right across the site which have been refurbished. Even though the exterior might look old, they would look brand new on the inside. For example, 9A on A block, is the cancer ward. You would walk in and you would imagine you were in a brand new building.

The project is going from strength to strength. B block was demolished in the first half of this year. Loading out occurred in the first half of the year, piling and structural retention works are occurring in the second half of the year.

The delays in occupying the temporary inpatient building, J block, have contributed to a delay in the anticipated completion date. I am advised that is now mid-2019. It does not change the contracted completion date of December 2018. The Government is committed to the project's completion and the assistance provided to the operating hospital.

Mr VALENTINE - I am interested in the governance structure of the project? Not just the committee, but people listening might understand the complexity we are dealing with here.

Mr FERGUSON - I am going to ask Mr Moloney to join me in answering this. The project is governed by an executive steering committee which is comprised of cross agency participation. The chair of that committee was Dr Dan Norton. He has recently left that role, he asked to be retired. The executive steering committee is now chaired by Mr Rhys Edwards. Ben reports to the committee and to me. Ben and his colleagues have project directorship.

Mr VALENTINE - The steering committee, not a rowing committee.

Mr MOLONEY - Yes, definitely. The executive steering committee is made up of highly capable people, including Michael Pervan at the table here. It has been very efficient in giving direction to the project. It has been very efficient in responding to quite complex decisions that the project has had to make as we have been progressing through. It has successfully steered it to the point where we have demolished B block and are progressing with the foundations so we can start coming out of the ground by the end of the year.

Mr VALENTINE - What other communication structures with staff exist? Do you put out regular newsletters to staff so they understand what is going on, how decanting is going and what issues and problems exist on a daily basis with a project like that? I am broadly interested. We do not have a week, obviously.

Mr MOLONEY - The project also reports to the project control group, which has broad representation from the hospital and the Tasmanian Health Service. In relation to communication with staff we have a range of user groups that form that consultation. We publish a newsletter every two months and we provide fact sheets and other forms of information to give the staff and the broader public information we think is relevant. For instance, we might release a fact sheet on the demolition process or Government arrangements. We recently updated our Government fact sheet to show the appointment of the new chair.

Mr VALENTINE - Do you have communication protocols with external parties that might be affected by what si happening at the hospital?

Mr MOLONEY - We try to engage with impacted stakeholders. For instance we have met with residents who live near the hospital who may be affected by the recent construction work and the establishment of a construction site.

Mr VALENTINE - What about service providers to the hospital? Do you have a protocol to deal with them?

Mr MOLONEY - Yes, there is probably a range of service providers there. We rely primarily on the Tasmanian Health Service to communicate with providers of clinical services. We communicate through them since the service providers are working for them. There are other service providers which are in the logistical space. As part of the project we had to temporarily relocate the loading dock, so we have had to communicate with all the delivery truck drivers to make sure they understood that the loading dock was moving.

Mr VALENTINE - It is not an insignificant project obviously. Have you project management protocols, the state government project management guidelines that you follow?

Mr MOLONEY - We operate under a range of structures. We draw on information from the Tasmanian government project management guidelines for some of the project's guiding principles.

The team I am responsible for is headed by two sections. One is our external project management consultants, Capital Insights. They have been engaged to draw from experience in both hospital construction and the broader capital works experience. The other side of the team are Tasmanian Health Service employees which bring Tasmanian knowledge and the knowledge of how the hospital operates and who to liaise with. Their point of contact is primarily with a lot of stakeholder management to feed information into the project and make sure we are able to procure the correct furniture fittings and equipment, and to develop our operational commissioning planning as well. One of the real challenges for these projects is moving into the new facility and making sure everyone knows how to operate out of that new facility and can do so efficiently.

Mr VALENTINE - Thank you, Mr Moloney.

Ms FORREST - Minister, you do not have those answers to questions I sent through to your office last week?

Mr FERGUSON - No, I don't.

Ms FORREST - Or the attachments to the questions? I will give them to the secretary and he will attach them to that letter. You already have a copy of that re-attachment.

CHAIR - Thank you very much for your staff today.

DIVISION 7
(Department of Premier and Cabinet)

Minister for Information Technology and Innovation

Output group 3
Electronic services for government agencies and the community

3.1 Information, technology and digital services strategy and policy development -

CHAIR - We are right to go, minister.

Mr FERGUSON - Chair and committee, if I can introduce Mr Kim Evans, Secretary to the Department of State Growth, who assists me with information technology industry-facing matters. To my right, Deputy Secretary of the Department of Premier and Cabinet Ruth McArdle, joined by Katie Ault, who is with TMD Division.

CHAIR - Thank you very much, minister, and we will move straight into it. I do not think there are any questions are there, Mr Valentine?

Ms FORREST - You can't have them waiting all that time and then send them home.

Mr VALENTINE - There goes another one, Chair, down the end, the person running around the edge of the lawn with the pantyhose on their head and chewing Jaffas and being very parsimonious.

CHAIR - We will allow Mr Valentine to fire away.

Mr VALENTINE - The question is with respect to the breakdown of what has been funded. I know on page 199 there are some components of it but maybe not everything. Can we have a full breakdown of what has been funded in this Budget?

Mr FERGUSON - Mr Valentine, I apologise but my trusty adviser has taken my budget paper No. 1 but that will not stop me from speaking about our investments. I presume you are referring to the digital transformation fund?

Mr VALENTINE - I am referring to that, on page 119, plus anything extra that you can inform me of. I have heard quite a bit of it; as you know, we went to a function together not that long ago but for the committee's sake and for those who are listening, perhaps you might outline it.

Mr FERGUSON - I certainly shall. First of all, the Government recognises the importance of IT and innovation in the Tasmanian community and the economy. It is a driver of future large-scale investment for our state and the work that has been done in the past 12 months shows the Government's commitment to the future of a robust and active ICT sector. In the roll across government, the Government has allocated over $60 million for the Digital Transformation Priority Expenditure Program, which aims to transform ICT systems to support our frontline workers, our hardworking public servants, to deliver services that Tasmanians use and need.

Of that, $13.6 million has been allocated to support police through the replacement of the core legacy operating system utilised by Tasmania Police. That project is known as Project Unify. Funding has also been provided to undertake preparation of detailed design work for the Justice Connect criminal information management system and the Child and Youth Services client information system to support child and youth workers.

In addition to that locked-in funding of $13.6 million, there is a provision of $50 million that has been made to fund the implementation of a range of IT projects once initial design work and costings are confirmed through the Treasury structure investment review process, or SIRP for short. Treasury will lead work to develop a digital transformation project strategy which will set stage gates and criteria for the release of ICT project funding as part of SIRP. The strategy will include development principles such as: the requirement to consider whole-of-government impacts; whole-of-government standards in digital design; security and management of data - those requirements set by the office of eGovernment; across-agency integration; and benefits realisation, both for the community and internally, to make sure that value is actually delivered by each project. Treasury will work together with the office of eGovernment and key agencies to ensure the funding strategy supports the Government's ICT strategy and priorities. That is the overview of the work across government.

The Department of State Growth initiatives under this portfolio cover building ICT workforce capability, Digital Ready for Business, free public Wi-Fi, the partnership that we have with the Commonwealth on mobile black spots, and also STEM activities and Sense-T. In building ICT workforce capability, the Government has invested in subsidies for 1133 different ICT vocational qualifications last year; $50 000 was announced in last year's Budget to pilot the TASICT Generations project which, Mr Valentine, you would have heard me praising last Friday evening at the event.

The Department of State Growth, mainly through Skills Tasmania, has several deeds of grant with our industry representative, TASICT, to support a variety of activities in the industry, particularly Code Club, IT@Work and IT is Your Career[TBC?can't find last one].

There is more in the Budget, especially to Mr Armstrong's question earlier to me today about Digital Ready for Business. May I address that as well?

Mr VALENTINE - Yes.

Mr FERGUSON - Under the small business policy that the Government took to the last election, we have committed $800 000 over four years to provide the small business community with the information and tools they require to help them make the most of online services and the opportunities that are available to them. This is a program started by the previous government. We looked at it and said it is worth continuing and have done so, and over time we have improved it with a deeper reach into the state's business community. We are extending that again and the Budget provides an additional commitment of $900 000 over four years to expand the scope of the program. As at April this year, approximately 2980 registrations have been recorded since the program recommenced in 2014.

We have set up a very successful free public Wi-Fi network. That has now reached 149 access points in 57 separate locations around the state and we will be rolling out a small number in the very near future. This is our partnership with Telstra, which successfully won the procurement process to build, own and manage that network. Since the network was switched on in December 2015, across the entire network some 265 000 users had accessed the service in almost 580 000 sessions with the service now averaging 1570 users per day. Who doesn't like free Wi-Fi? The real purpose is to encourage the visitors to our state. The web app and the app on your phone, which you can download, helps the tourists to know where else they can get free Wi-Fi and to tell their friends and family back home about the wonderful experiences they are enjoying.

Mr VALENTINE - Are you able to track them so you know where they are going?

Mr FERGUSON - We are not. There is an element of MAC address tracking but it is at a very basic level.

Mr VALENTINE - I am not suggesting you are spying on them.

Mr FERGUSON - If you want to catch up with Sense-T sometime, they have a wonderful track tourist app they have been encouraging people to download.

Mobile black spot has been funded. There are 31 Tasmanian black spots under round 1 of that Commonwealth program. Tasmania has partnered there and made some co-investments to help make that happen and leverage it further. A further six Tasmanian black spots are funded under round 2.

These are the main announcements in the Budget to comprehensively touch on your question on what else the Budget might be doing.

Mr VALENTINE - Thank you for that. Can you table the black spot areas?

Mr FERGUSON - If I could take that on notice, I would be happy to do that.

Mr VALENTINE - The ICT industry would be interested in seeing some funding to grow their sector. Do you have anything in mind into the future? There does not seem to be much in

here. Yes, there is for small business and I understand that, but I am talking about the ICT sector itself.

Mr FERGUSON - May clarify the question? Are you referring to the sector in the broad or the sector as its representative organisation?

Mr VALENTINE - The ICT sector itself. If you are trying to encourage people to develop a product in this state, it is a product that does not have a great freight component to it and is not presenting a problem for us. ICT is pretty good in growing the economic strength of the state.

Mr FERGUSON - Absolutely. We are making significant investments in the sector per se. The Government has recently made a strategic decision to invest in one particular initiative with a company by the name of DXC. This is a merit-based process whereby consideration was sought and granted on the advice of the Tasmanian Development Board. This is an initiative that is increasing the workforce of that business here in Tasmania. You might know this organisation better named as a UXC. It has more recently been acquired and has a new name, DXC. In 2015 we started this engagement and this business made a commitment to Tasmania of up to 50 new jobs and maintaining a total of at least 62 in our state for a guaranteed five years. Following a recommendation from the Tasmanian Development Board, the Government approved an assistance package of up to $1.7 million for a term of those five years. That is a combination of support and payroll tax reimbursement.

Mr VALENTINE - Is this a research and development business?

Mr FERGUSON - DXC is a customer service enterprise. It supports enterprises delivering their customer service around Australia and potentially further a field. They have taken up residency in your electorate in the Retirement Benefits Fund building and I invite go and find out more. DXC has built up strong links with TasTAFE and UTas and in April of this year following a further recommendation of the TD board, the Government approved an additional assistance package to DXC, of up to $1.36 million for a further term of five years to support 50 additional jobs. This includes expansion support and payroll tax reimbursement. We are now looking at 112 FTEs of new and highly skilled retained ICT professionals providing a very significant additional secondary benefit to the wider Tasmanian economy, valued in excess of $8 million a year.

I visited DXC prior to any of these arrangements coming into place and there were something like 8-10 staff in a part of the ABC building. It has been a really quite significant investment by that company in our state, with some support by our Government. That is the nature of the kind of support that remains potentially on offer, where the merits exist for other similar investments in future.

Mr VALENTINE - It is quite clear that could end up being very good support and maybe there is reason to be looking at other support into the future.

Mr FERGUSON - Indeed.

Mr VALENTINE - With infrastructure funds being put towards the sub partners/Indigo submarine cable project, are there any funds from the state Government? Those advocating say this is a once in a generation opportunity. It is everybody's benefit to be passing through and not across Bass Strait. The opportunity is to link into that.

Mr FERGUSON - The Government has its eyes wide open on this project. Significant measures to seek professional advice from experts has allowed Government to be fully informed about our options. The project has been largely known as the SubPartners project or APX-Central is now known as the INDIGO Consortium and includes SubPartners as a member of that consortium. Since we last met on 6 April of this year, INDIGO Consortium reached agreement to proceed with the Perth to Sydney submarine fibre optic cable. A contract now in force with each of those parties. That has triggered the commencement of further engagement with Government. The Secretary, Mr Evans, as well as the Coordinator-General, Mr Perry, have been commissioned to engage with the consortium to examine whether or not there is an opportunity for Government here.

Given the commercial nature of the consortium's developments, I am not able to offer further information at this time. I gave you that long preamble to assure you we are very aware of the potential. The Government is taking all responsible steps to ensure that any Tasmanian involvement is considered.

Mr VALENTINE - I appreciate that fulsome response. With respect to the cyber security project, the $300 000 a year in the forward Estimates, I was reading some notes on this in the budget papers and I wonder if agencies are going to retain levels of responsibility in their particular agency for this project. Is there a possibility it could become a bit fragmented or disjointed in the timeliness of approach to get this project happening in the right direction? Aren't there vulnerabilities there if you are letting agencies do their own thing?

Ms McARDLE - We are letting[leading?] agencies but this role would be about coordinating what agencies are doing and making sure, from a whole-of-government perspective, we have that oversight and are building capability within agencies. We would be working very much with agencies and ensuring we are doing it to an appropriate standard and in a coordinated way.

Mr FERGUSON - There is always risk and we as a government, through the vehicle of DPAC as the lead agency, have been very mindful of the need to ensure that we manage our risk to an increasingly higher standard. The cyber security program will augment existing agency efforts to coordinate and build cyber security capability across government and to undertake targeted assessment of cyber security risks to government.

The Government is using existing funds to create a new position of whole-of-government Tasmanian Government chief information security officer. The additional allocation of $1.2 million over four years enables, when we recruit that person to that role, the chief information security officer to have a support officer and more effectively do their role: build capability, coordinate, and undertake cyber security risk assessments. That work also will be conducted in collaboration with agencies that will also have responsibility for their individual cyber security. However, the program will also coordinate whole-of-government activities with the Australian Government, including the Department of Prime Minister and Cabinet's Cyber Policy Branch, the Australian Signals Directorate and the Australian Cyber Security Centre. On 19 June, this month, the Government will be briefed on the current cyber security landscape by the special adviser to the Prime Minister on cyber security.

Taken as a whole, what we are doing here is building that capability of agencies within government, not stranding them but keeping them all part of the whole-of-government concern, consistent with our IT policy.

Mr VALENTINE - At the end of the day the WannaCrys of this world are not going to get too much joy out of trying to enter state government territory?

Mr FERGUSON - We are fortunate it has not been an issue for us and that is an indication of our preparedness and fortune.

Mr VALENTINE - Preparedness of Microsoft maybe.

Mr FERGUSON - We cannot be complacent, and I know you agree with that. Australia, as I understand, was not specifically targeted by WannaCry. Had we been, maybe some different states and territories might have had a less happy picture. There have been incidents of it in our country, not that I am aware of in Tasmania. This is just an illustration of the danger of ransomware attacks like that. We want to ensure that our services are absolutely protected, not just from the fear of being encrypted and lost to us and held to ransom, but that we protect the integrity of Tasmanian people's confidential data. That is top of mind and it is with all that in mind we are recruiting that expert capability within government.

Mr VALENTINE - In your preamble you were talking about the integration of the State Service ICT. Can you explain a little bit more about that - is it back office functions you are working on for that? What is it that you are dealing with there?

Mr FERGUSON - We are building a new Tasmanian Cloud environment. It is quite a detailed architecture which the ladies to my right are far more expert in than me. They are building it for us. I will invite Katie and Ruth to expand on that and where we are at with building the panel of providers and ultimately the new core.

Ms AULT - Thank you, Mr Valentine. With the Tasmanian Cloud, as you know, we have a set of arrangements for delivering communications technology for agencies, connection services, internet, the core arrangements and all of that. What is new is the Tasmanian Cloud policy, which is about agencies moving all of their information and data into the outsourced fit-for-purpose data centre at service locations and, in the longer term, infrastructure as a service. We have been running a series of procurements, new internet services, new connection services, $150 million worth of new outsourced arrangements with the exception of AARNet, which delivers education over the internet and all local suppliers.

The infrastructure as a service part is the newest and most advanced and different for agencies so there has not yet been significant movement into those arrangements. Agencies are on track to have all suitable data and services in those Tasmanian Cloud arrangements in accordance with the Tasmanian Cloud Policy by the end of 2018.

The last of the Networking Tasmania three procurements that are underway is the new core agreement, which has a range of new security features. We are currently in the final stages of direct negotiations with Telstra to deliver that component.

Mr VALENTINE - What about office stuff, enterprise agreements with Microsoft and those sorts of things, are they still in existence?

Ms AULT - They are still in existence. The C141 as it is known, the enterprise agreement, and the underlying whole-of-government agreement with Microsoft is actually run out of Treasury, not managed by the minister; those arrangements are in place. There has been a range of strategic

conversations underway with Microsoft about how we can do better in that space, particularly as in the long-term cloud-type arrangements might occur. We also have local companies which are interested in doing those sorts of cloud services on-island in accordance with the Government's preference.

Mr VALENTINE - The last question is about the voice-over-IP telephone services. What is happening there? Is that fully implemented across the State Service?

Mr FERGUSON - It certainly is. The Connect V project -

Ms AULT - The original voice-over-IP change project is completed. There are a small number of what we call mop-up services, fax lines, lift phones and those sorts of things that were not completed in that original rollout that have been set aside because the Government is now in the process of moving to a new supplier for those services.

Mr VALENTINE - Thank you.

DEPUTY CHAIR - Are there any other questions on IT? There not being thank you, minister and thank you, staff for hanging around waiting for us to complete the other, slightly larger portfolio. We will close the meeting and we will have a brief meeting ourselves. We will write to you regarding those questions on notice.

The committee adjourned at 5.44 p.m.